



Senate

General Assembly

File No. 426

February Session, 2018

Substitute Senate Bill No. 16

Senate, April 12, 2018

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist. and SEN. SOMERS of the 18th Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS REGARDING PUBLIC HEALTH.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 4-28f of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2018*):

3 (a) There is created a Tobacco and Health Trust Fund which shall be
4 a separate nonlapsing fund. The purpose of the trust fund shall be to
5 create a continuing significant source of funds to (1) support and
6 encourage development of programs to reduce tobacco abuse through
7 prevention, education and cessation programs, (2) support and
8 encourage development of programs to reduce substance abuse, and
9 (3) develop and implement programs to meet the unmet physical and
10 mental health needs in the state.

11 (b) The trust fund may accept transfers from the Tobacco Settlement
12 Fund and may apply for and accept gifts, grants or donations from

13 public or private sources to enable the trust fund to carry out its
14 objectives.

15 (c) The trust fund shall be administered by a board of trustees,
16 except that the board shall suspend its operations from July 1, 2003, to
17 June 30, 2005, inclusive. The board shall consist of seventeen trustees.
18 The appointment of the initial trustees shall be as follows: (1) The
19 Governor shall appoint four trustees, one of whom shall serve for a
20 term of one year from July 1, 2000, two of whom shall serve for a term
21 of two years from July 1, 2000, and one of whom shall serve for a term
22 of three years from July 1, 2000; (2) the speaker of the House of
23 Representatives and the president pro tempore of the Senate each shall
24 appoint two trustees, one of whom shall serve for a term of two years
25 from July 1, 2000, and one of whom shall serve for a term of three years
26 from July 1, 2000; (3) the majority leader of the House of
27 Representatives and the majority leader of the Senate each shall
28 appoint two trustees, one of whom shall serve for a term of one year
29 from July 1, 2000, and one of whom shall serve for a term of three years
30 from July 1, 2000; (4) the minority leader of the House of
31 Representatives and the minority leader of the Senate each shall
32 appoint two trustees, one of whom shall serve for a term of one year
33 from July 1, 2000, and one of whom shall serve for a term of two years
34 from July 1, 2000; and (5) the Secretary of the Office of Policy and
35 Management, or the secretary's designee, shall serve as an ex-officio
36 voting member. Following the expiration of such initial terms,
37 subsequent trustees shall serve for a term of three years. The period of
38 suspension of the board's operations from July 1, 2003, to June 30, 2005,
39 inclusive, shall not be included in the term of any trustee serving on
40 July 1, 2003. The trustees shall serve without compensation except for
41 reimbursement for necessary expenses incurred in performing their
42 duties. The board of trustees shall establish rules of procedure for the
43 conduct of its business which shall include, but not be limited to,
44 criteria, processes and procedures to be used in selecting programs to
45 receive money from the trust fund. The trust fund shall be within the
46 Office of Policy and Management for administrative purposes only.
47 The board of trustees shall, [meet not less than biannually, except

48 during the fiscal years ending June 30, 2004, and June 30, 2005, and,]
49 not later than January first of each year, except [during the fiscal years
50 ending June 30, 2004, and June 30, 2005] following a fiscal year in
51 which the trust fund does not receive a deposit from the Tobacco
52 Settlement Fund, shall submit a report of its activities and
53 accomplishments to the joint standing committees of the General
54 Assembly having cognizance of matters relating to public health and
55 appropriations and the budgets of state agencies, in accordance with
56 section 11-4a.

57 (d) (1) During the period commencing July 1, 2000, and ending June
58 30, 2003, the board of trustees, by majority vote, may recommend
59 authorization of disbursement from the trust fund for the purposes
60 described in subsection (a) of this section and section 19a-6d, provided
61 the board may not recommend authorization of disbursement of more
62 than fifty per cent of net earnings from the principal of the trust fund
63 for such purposes. For the fiscal year commencing July 1, 2005, and
64 each fiscal year thereafter, the board may recommend authorization of
65 the net earnings from the principal of the trust fund for such purposes.
66 For the fiscal year ending June 30, 2009, and each fiscal year thereafter,
67 the board may recommend authorization of disbursement for such
68 purposes of (A) up to one-half of the annual disbursement from the
69 Tobacco Settlement Fund to the Tobacco and Health Trust Fund from
70 the previous fiscal year, pursuant to section 4-28e, up to a maximum of
71 six million dollars per fiscal year, and (B) the net earnings from the
72 principal of the trust fund from the previous fiscal year. For the fiscal
73 year ending June 30, 2014, and each fiscal year thereafter, the board
74 may recommend authorization of disbursement of up to the total
75 unobligated balance remaining in the trust fund after disbursement in
76 accordance with the provisions of the general statutes and relevant
77 special and public acts for such purposes, not to exceed twelve million
78 dollars per fiscal year. The board's recommendations shall give (i)
79 priority to programs that address tobacco and substance abuse and
80 serve minors, pregnant women and parents of young children, and (ii)
81 consideration to the availability of private matching funds.
82 Recommended disbursements from the trust fund shall be in addition

83 to any resources that would otherwise be appropriated by the state for
84 such purposes and programs.

85 (2) Except during the fiscal years ending June 30, 2004, and June 30,
86 2005, the board of trustees shall submit such recommendations for the
87 authorization of disbursement from the trust fund to the joint standing
88 committees of the General Assembly having cognizance of matters
89 relating to public health and appropriations and the budgets of state
90 agencies. Not later than thirty days after receipt of such
91 recommendations, said committees shall advise the board of their
92 approval, modifications, if any, or rejection of the board's
93 recommendations. If said joint standing committees do not concur, the
94 speaker of the House of Representatives, the president pro tempore of
95 the Senate, the majority leader of the House of Representatives, the
96 majority leader of the Senate, the minority leader of the House of
97 Representatives and the minority leader of the Senate each shall
98 appoint one member from each of said joint standing committees to
99 serve as a committee on conference. The committee on conference shall
100 submit its report to both committees, which shall vote to accept or
101 reject the report. The report of the committee on conference may not be
102 amended. If a joint standing committee rejects the report of the
103 committee on conference, the board's recommendations shall be
104 deemed approved. If the joint standing committees accept the report of
105 the committee on conference, the joint standing committee having
106 cognizance of matters relating to appropriations and the budgets of
107 state agencies shall advise the board of said joint standing committees'
108 approval or modifications, if any, of the board's recommended
109 disbursement. If said joint standing committees do not act within thirty
110 days after receipt of the board's recommendations for the
111 authorization of disbursement, such recommendations shall be
112 deemed approved. Disbursement from the trust fund shall be in
113 accordance with the board's recommendations as approved or
114 modified by said joint standing committees.

115 (3) After such recommendations for the authorization of
116 disbursement have been approved or modified pursuant to

117 subdivision (2) of this subsection, any modification in the amount of an
118 authorized disbursement in excess of fifty thousand dollars or ten per
119 cent of the authorized amount, whichever is less, shall be submitted to
120 said joint standing committees and approved, modified or rejected in
121 accordance with the procedure set forth in subdivision (2) of this
122 subsection. Notification of all disbursements from the trust fund made
123 pursuant to this section shall be sent to the joint standing committees
124 of the General Assembly having cognizance of matters relating to
125 public health and appropriations and the budgets of state agencies,
126 through the Office of Fiscal Analysis.

127 (4) The board of trustees shall, not later than February first of each
128 year, except [during the fiscal years ending June 30, 2004, and June 30,
129 2005] following a fiscal year in which the trust fund does not receive a
130 deposit from the Tobacco Settlement Fund, submit a report to the
131 General Assembly, in accordance with the provisions of section 11-4a,
132 that includes all disbursements and other expenditures from the trust
133 fund and an evaluation of the performance and impact of each
134 program receiving funds from the trust fund. Such report shall also
135 include the criteria and application process used to select programs to
136 receive such funds.

137 Sec. 2. Subsection (a) of section 19a-55 of the 2018 supplement to the
138 general statutes is repealed and the following is substituted in lieu
139 thereof (*Effective October 1, 2018*):

140 (a) The administrative officer or other person in charge of each
141 institution caring for newborn infants shall cause to have administered
142 to every such infant in its care an HIV-related test, as defined in section
143 19a-581, a test for phenylketonuria and other metabolic diseases,
144 hypothyroidism, galactosemia, sickle cell disease, maple syrup urine
145 disease, homocystinuria, biotinidase deficiency, congenital adrenal
146 hyperplasia, severe combined immunodeficiency disease,
147 adrenoleukodystrophy and such other tests for inborn errors of
148 metabolism as shall be prescribed by the Department of Public Health.
149 The tests shall be administered as soon after birth as is medically

150 appropriate. If the mother has had an HIV-related test pursuant to
151 section 19a-90 or 19a-593, the person responsible for testing under this
152 section may omit an HIV-related test. The Commissioner of Public
153 Health shall (1) administer the newborn screening program, (2) direct
154 persons identified through the screening program to appropriate
155 specialty centers for treatments, consistent with any applicable
156 confidentiality requirements, and (3) set the fees to be charged to
157 institutions to cover all expenses of the comprehensive screening
158 program including testing, tracking and treatment. The fees to be
159 charged pursuant to subdivision (3) of this subsection shall be set at a
160 minimum of ninety-eight dollars. The Commissioner of Public Health
161 shall publish a list of all the abnormal conditions for which the
162 department screens newborns under the newborn screening program,
163 which shall include screening for amino acid disorders, organic acid
164 disorders and fatty acid oxidation disorders, including, but not limited
165 to, long-chain 3-hydroxyacyl CoA dehydrogenase (L-CHAD), [and]
166 medium-chain acyl-CoA dehydrogenase (MCAD) and, subject to the
167 approval of the Secretary of the Office of Policy and Management, any
168 other disorder included on the recommended uniform screening panel
169 pursuant to 42 USC 300b-10, as amended from time to time.

170 Sec. 3. (*Effective July 1, 2018*) The amount of the payments made by
171 the state to full-time municipal health departments, pursuant to section
172 19a-202 of the general statutes, and to health districts, pursuant to
173 section 19a-245 of the general statutes, shall be reduced
174 proportionately in the event that the total of such payments in a fiscal
175 year exceeds the amount appropriated for the purposes of said sections
176 with respect to such fiscal year.

177 Sec. 4. Subsection (a) of section 19a-490 of the 2018 supplement to
178 the general statutes is repealed and the following is substituted in lieu
179 thereof (*Effective from passage*):

180 (a) "Institution" means a hospital, short-term hospital special
181 hospice, hospice inpatient facility, residential care home, nursing home
182 facility, home health care agency, homemaker-home health aide

183 agency, behavioral health facility, assisted living services agency,
184 substance abuse treatment facility, outpatient surgical facility,
185 outpatient clinic, an infirmary operated by an educational institution
186 for the care of students enrolled in, and faculty and employees of, such
187 institution; a facility engaged in providing services for the prevention,
188 diagnosis, treatment or care of human health conditions, including
189 facilities operated and maintained by any state agency; [, except
190 facilities for the care or treatment of mentally ill persons or persons
191 with substance abuse problems;] and a residential facility for persons
192 with intellectual disability licensed pursuant to section 17a-227 and
193 certified to participate in the Title XIX Medicaid program as an
194 intermediate care facility for individuals with intellectual disability.
195 "Institution" does not include any facility for the care and treatment of
196 persons with mental illness or substance use disorder operated or
197 maintained by any state agency, except Whiting Forensic Hospital;

198 Sec. 5. Subdivision (18) of subsection (b) of section 1-210 of the 2018
199 supplement to the general statutes is repealed and the following is
200 substituted in lieu thereof (*Effective from passage*):

201 (18) Records, the disclosure of which the Commissioner of
202 Correction, or as it applies to Whiting Forensic [Division facilities of
203 the Connecticut Valley] Hospital, the Commissioner of Mental Health
204 and Addiction Services, has reasonable grounds to believe may result
205 in a safety risk, including the risk of harm to any person or the risk of
206 an escape from, or a disorder in, a correctional institution or facility
207 under the supervision of the Department of Correction or Whiting
208 Forensic [Division facilities] Hospital. Such records shall include, but
209 are not limited to:

210 (A) Security manuals, including emergency plans contained or
211 referred to in such security manuals;

212 (B) Engineering and architectural drawings of correctional
213 institutions or facilities or Whiting Forensic [Division] Hospital
214 facilities;

215 (C) Operational specifications of security systems utilized by the
216 Department of Correction at any correctional institution or facility or
217 Whiting Forensic [Division] Hospital facilities, except that a general
218 description of any such security system and the cost and quality of
219 such system may be disclosed;

220 (D) Training manuals prepared for correctional institutions and
221 facilities or Whiting Forensic [Division] Hospital facilities that
222 describe, in any manner, security procedures, emergency plans or
223 security equipment;

224 (E) Internal security audits of correctional institutions and facilities
225 or Whiting Forensic [Division] Hospital facilities;

226 (F) Minutes or recordings of staff meetings of the Department of
227 Correction or Whiting Forensic [Division] Hospital facilities, or
228 portions of such minutes or recordings, that contain or reveal
229 information relating to security or other records otherwise exempt
230 from disclosure under this subdivision;

231 (G) Logs or other documents that contain information on the
232 movement or assignment of inmates or staff at correctional institutions
233 or facilities; and

234 (H) Records that contain information on contacts between inmates,
235 as defined in section 18-84, and law enforcement officers;

236 Sec. 6. Subsection (c) of section 1-210 of the 2018 supplement to the
237 general statutes is repealed and the following is substituted in lieu
238 thereof (*Effective from passage*):

239 (c) Whenever a public agency receives a request from any person
240 confined in a correctional institution or facility or a Whiting Forensic
241 [Division] Hospital facility, for disclosure of any public record under
242 the Freedom of Information Act, the public agency shall promptly
243 notify the Commissioner of Correction or the Commissioner of Mental
244 Health and Addiction Services in the case of a person confined in a
245 Whiting Forensic [Division] Hospital facility of such request, in the

246 manner prescribed by the commissioner, before complying with the
247 request as required by the Freedom of Information Act. If the
248 commissioner believes the requested record is exempt from disclosure
249 pursuant to subdivision (18) of subsection (b) of this section, the
250 commissioner may withhold such record from such person when the
251 record is delivered to the person's correctional institution or facility or
252 Whiting Forensic [Division] Hospital facility.

253 Sec. 7. Section 5-145a of the general statutes is repealed and the
254 following is substituted in lieu thereof (*Effective from passage*):

255 Any condition of impairment of health caused by hypertension or
256 heart disease resulting in total or partial disability or death to a
257 member of the security force or fire department of The University of
258 Connecticut or the aeronautics operations of the Department of
259 Transportation, or to a member of the Office of State Capitol Police or
260 any person appointed under section 29-18 as a special policeman for
261 the State Capitol building and grounds, the Legislative Office Building
262 and parking garage and related structures and facilities, and other
263 areas under the supervision and control of the Joint Committee on
264 Legislative Management, or to state personnel engaged in guard or
265 instructional duties in the Connecticut Correctional Institution,
266 Somers, Connecticut Correctional Institution, Enfield-Medium, the
267 Carl Robinson Correctional Institution, Enfield, John R. Manson Youth
268 Institution, Cheshire, the York Correctional Institution, the Connecticut
269 Correctional Center, Cheshire, or the community correctional centers,
270 or to any employee of the Whiting Forensic [Division] Hospital with
271 direct and substantial patient contact, or to any detective, chief
272 inspector or inspector in the Division of Criminal Justice or chief
273 detective, or to any state employee designated as a hazardous duty
274 employee pursuant to an applicable collective bargaining agreement
275 who successfully passed a physical examination on entry into such
276 service, which examination failed to reveal any evidence of such
277 condition, shall be presumed to have been suffered in the performance
278 of his duty and shall be compensable in accordance with the
279 provisions of chapter 568, except that for the first three months of

280 compensability the employee shall continue to receive the full salary
281 which he was receiving at the time of injury in the manner provided
282 by the provisions of section 5-142. Any such employee who began such
283 service prior to June 28, 1985, and was not covered by the provisions of
284 this section prior to said date shall not be required, for purposes of this
285 section, to show proof that he successfully passed a physical
286 examination on entry into such service.

287 Sec. 8. Section 5-173 of the general statutes is repealed and the
288 following is substituted in lieu thereof (*Effective from passage*):

289 (a) A state policeman in the active service of the Division of State
290 Police within the Department of Emergency Services and Public
291 Protection, or any person who is engaged in guard or instructional
292 duties at the Connecticut Correctional Institution, Somers, the
293 Connecticut Correctional Institution, Enfield-Medium, the Carl
294 Robinson Correctional Institution, Enfield, the John R. Manson Youth
295 Institution, Cheshire, the York Correctional Institution, the Connecticut
296 Correctional Center, Cheshire and the community correctional centers,
297 or any person exempt from collective bargaining who is engaged in
298 custodial or instructional duties within the Department of Correction,
299 or any person who is an employee of the Whiting Forensic [Division]
300 Hospital with direct and substantial patient contact, or any person who
301 is employed as a correctional counselor, correctional counselor
302 supervisor, parole officer or parole supervisor or in a comparable job
303 classification by the Board of Pardons and Paroles, or any member of
304 tier I who has been designated as a hazardous duty member pursuant
305 to an applicable collective bargaining agreement, who has reached his
306 forty-seventh birthday and completed at least twenty years of
307 hazardous duty service for the state or service as a state policeman or
308 as guard or instructor at said correctional institutions or correctional
309 centers, or service in a custodial or instructional position within the
310 Department of Correction which is exempt from collective bargaining,
311 or as an employee of the Whiting Forensic [Division] Hospital or its
312 predecessor institutions, or as a correctional counselor, correctional
313 counselor supervisor, parole officer or parole supervisor or in a

314 comparable job classification as an employee of the Board of Pardons
315 and Paroles, shall be retired on his own application or on the
316 application of the Commissioner of Emergency Services and Public
317 Protection or the Commissioner of Correction, as the case may be.

318 (b) On or after October 1, 1982, each such person shall receive a
319 monthly retirement income equal to one-twelfth of (1) fifty per cent of
320 his base salary, as defined in subsection (b) of section 5-162, for such
321 twenty years of service, plus (2) two per cent of his base salary for each
322 year, taken to completed months, of Connecticut state service in excess
323 of twenty years, except that any such person who is both a member of
324 the Division of State Police within the Department of Emergency
325 Services and Public Protection and a member of part B shall receive a
326 permanently reduced retirement income upon reaching the age of
327 sixty-five or, if earlier, upon receipt of Social Security disability
328 benefits or, for any such state policeman, upon receipt of benefits
329 under subsection (d) of section 5-142. Any such state police member
330 shall have his monthly retirement income reduced by an amount equal
331 to one-twelfth of one per cent of four thousand eight hundred dollars
332 multiplied by the number of years of state service, taken to completed
333 months.

334 (c) Any such person who, while so employed, was granted military
335 leave to enter the armed forces, as defined by section 27-103, and who,
336 upon his discharge and within ninety days, returned to such service,
337 shall be granted retirement credit for any period of service in time of
338 war, as defined by said section, and for military service during a
339 national emergency declared by the President of the United States on
340 and after September 1, 1939, toward the required minimum of twenty
341 [years] years service; and any such person may be granted credit for
342 any such war service prior to such employment upon payment of
343 contributions and interest computed in accordance with subsection (b)
344 of section 5-180, but such service shall not be counted toward the
345 minimum service requirement of twenty years.

346 (d) Any such person who, after retiring from hazardous duty as

347 designated pursuant to a collective bargaining agreement or from the
348 Division of State Police or the employ of the Connecticut Correctional
349 Institution, Somers, the Connecticut Correctional Institution, Enfield-
350 Medium, the Carl Robinson Correctional Institution, Enfield, the John
351 R. Manson Youth Institution, Cheshire, the York Correctional
352 Institution, the Connecticut Correctional Center, Cheshire or a
353 community correctional center, the Whiting Forensic [Division]
354 Hospital or the Board of Pardons and Paroles, as the case may be, is
355 employed by any other state agency may elect to receive the retirement
356 income to which he was entitled at the time of his retirement from such
357 hazardous duty or as a state policeman or employee of the correctional
358 institution or correctional center, forensic [division] hospital or Board
359 of Pardons and Paroles when his employment in such other agency
360 ceases, but he shall not, in that case, be entitled to any retirement
361 income by reason of service in such other agency except as provided in
362 subsection (g) of this section.

363 (e) Notwithstanding the provisions of subsection (a) of this section,
364 any state policeman who serves as Commissioner or Deputy
365 Commissioner of Emergency Services and Public Protection and whose
366 position as commissioner or deputy commissioner is terminated,
367 abolished or eliminated for any reason or who otherwise leaves such
368 position and who has completed twenty years of service as a state
369 policeman but who has not reached his forty-seventh birthday, shall be
370 entitled to a retirement income, in accordance with subsection (b) of
371 this section.

372 (f) A member who has completed twenty years of hazardous duty
373 service under this section, but who leaves such service on or after
374 October 1, 1982, but prior to reaching his forty-seventh birthday shall,
375 upon his own application be entitled to the benefits provided in
376 subsection (b) of this section at any time after reaching his forty-
377 seventh birthday.

378 (g) On and after October 1, 1982, an employee who has met the
379 twenty-year minimum service requirement and is thus eligible for

380 benefits under this section shall have any other Connecticut state
381 employment recognized in calculating the amount of his benefits.

382 Sec. 9. Subsection (d) of section 5-192f of the general statutes is
383 repealed and the following is substituted in lieu thereof (*Effective from*
384 *passage*):

385 (d) "Hazardous duty member" means a member who is a state
386 policeman in the active service of the Division of State Police within
387 the Department of Emergency Services and Public Protection, who is
388 engaged in guard or instructional duties at the Connecticut
389 Correctional Institution, Somers, the Connecticut Correctional
390 Institution, Enfield-Medium, the Carl Robinson Correctional
391 Institution, Enfield, the John R. Manson Youth Institution, Cheshire,
392 the York Correctional Institution, the Connecticut Correctional Center,
393 Cheshire or the community correctional centers, who is an employee of
394 the Whiting Forensic [Division] Hospital or its predecessor institutions
395 with direct and substantial patient contact, who is a detective, chief
396 inspector or inspector in the Division of Criminal Justice or chief
397 detective, who is employed as a correctional counselor, correctional
398 counselor supervisor, parole officer or parole supervisor or in a
399 comparable job classification by the Board of Pardons and Paroles, or
400 who has been designated as a hazardous duty member pursuant to the
401 terms of a collective bargaining agreement.

402 Sec. 10. Subsection (b) of section 17a-450 of the general statutes is
403 repealed and the following is substituted in lieu thereof (*Effective from*
404 *passage*):

405 (b) For the purposes of chapter 48, the Department of Mental Health
406 and Addiction Services shall be organized to promote comprehensive,
407 client-based services in the areas of mental health treatment and
408 substance abuse treatment and to ensure the programmatic integrity
409 and clinical identity of services in each area. The department shall
410 perform the functions of: Centralized administration, planning and
411 program development; prevention and treatment programs and
412 facilities, both inpatient and outpatient, for persons with psychiatric

413 disabilities or persons with substance use disorders, or both;
414 community mental health centers and community or regional
415 programs and facilities providing services for persons with psychiatric
416 disabilities or persons with substance use disorders, or both; training
417 and education; and research and evaluation of programs and facilities
418 providing services for persons with psychiatric disabilities or persons
419 with substance use disorders, or both. The department shall include,
420 but not be limited to, the following divisions and facilities or their
421 successor facilities: The office of the Commissioner of Mental Health
422 and Addiction Services; Capitol Region Mental Health Center;
423 Connecticut Valley Hospital, including the Addictions Division [, the
424 Whiting Forensic Division] and the General Psychiatric Division of
425 Connecticut Valley Hospital; the Whiting Forensic Hospital; the
426 Connecticut Mental Health Center; Ribicoff Research Center; the
427 Southwest Connecticut Mental Health System, including the Franklin
428 S. DuBois Center and the Greater Bridgeport Community Mental
429 Health Center; the Southeastern Mental Health Authority; River Valley
430 Services; the Western Connecticut Mental Health Network; and any
431 other state-operated facility for the treatment of persons with
432 psychiatric disabilities or persons with substance use disorders, or
433 both, but shall not include those portions of such facilities transferred
434 to the Department of Children and Families for the purpose of
435 consolidation of children's services.

436 Sec. 11. Subdivision (3) of subsection (c) of section 17a-450 of the
437 general statutes is repealed and the following is substituted in lieu
438 thereof (*Effective from passage*):

439 (3) Work with public or private agencies, organizations, facilities or
440 individuals to ensure the operation of the programs set forth in
441 accordance with sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-
442 484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as
443 amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576]
444 17a-575, as amended by this act, inclusive, 17a-580 to 17a-603,
445 inclusive, and 17a-615 to 17a-618, inclusive;

446 Sec. 12. Subsection (a) of section 17a-450a of the general statutes is
447 repealed and the following is substituted in lieu thereof (*Effective from*
448 *passage*):

449 (a) The Department of Mental Health and Addiction Services shall
450 constitute a successor department to the Department of Mental Health.
451 Whenever the words "Commissioner of Mental Health" are used or
452 referred to in the following general statutes, the words "Commissioner
453 of Mental Health and Addiction Services" shall be substituted in lieu
454 thereof and whenever the words "Department of Mental Health" are
455 used or referred to in the following general statutes, the words
456 "Department of Mental Health and Addiction Services" shall be
457 substituted in lieu thereof: 4-5, as amended by this act, 4-38c, 4-77a, 4a-
458 12, 4a-16, 5-142, 8-206d, 10-19, 10-71, 10-76d, 17a-14, 17a-26, 17a-31,
459 17a-33, 17a-218, 17a-246, 17a-450, as amended by this act, 17a-451, 17a-
460 453, 17a-454, 17a-455, 17a-456, 17a-457, 17a-458, as amended by this act,
461 17a-459, 17a-460, 17a-464, 17a-465, 17a-466, 17a-467, 17a-468, 17a-470,
462 as amended by this act, 17a-471, 17a-472, as amended by this act, 17a-
463 473, 17a-474, 17a-476, 17a-478, 17a-479, 17a-480, 17a-481, 17a-482, 17a-
464 483, 17a-484, 17a-498, as amended by this act, 17a-499, as amended by
465 this act, 17a-502, 17a-506, 17a-510, 17a-511, 17a-512, 17a-513, 17a-519, as
466 amended by this act, 17a-528, 17a-560, as amended by this act, 17a-561,
467 as amended by this act, 17a-562, as amended by this act, 17a-565, [17a-
468 576,] as amended by this act, 17a-581, 17a-582, 17a-675, 17b-28, 17b-59a,
469 as amended by this act, 17b-222, 17b-223, 17b-225, 17b-359, 17b-694,
470 19a-82, 19a-495, 19a-498, 19a-507a, 19a-507c, 19a-576, 19a-583, 20-14i,
471 20-14j, 21a-240, 21a-301, 27-122a, 31-222, 38a-514, 46a-28, 51-51o, 52-
472 146h and 54-56d.

473 Sec. 13. Subsection (c) of section 17a-458 of the general statutes is
474 repealed and the following is substituted in lieu thereof (*Effective from*
475 *passage*):

476 (c) "State-operated facilities" means those hospitals or other facilities
477 providing treatment for persons with psychiatric disabilities or for
478 persons with substance use disorders, or both, which are operated in

479 whole or in part by the Department of Mental Health and Addiction
480 Services. Such facilities include, but are not limited to, the Capitol
481 Region Mental Health Center, the Connecticut Valley Hospital,
482 including the Addictions Division [, the Whiting Forensic Division]
483 and the General Psychiatric Division of Connecticut Valley Hospital,
484 the Whiting Forensic Hospital, the Connecticut Mental Health Center,
485 the Franklin S. DuBois Center, the Greater Bridgeport Community
486 Mental Health Center and River Valley Services.

487 Sec. 14. Section 17a-470 of the general statutes is repealed and the
488 following is substituted in lieu thereof (*Effective from passage*):

489 Each state hospital, state-operated facility or the Whiting Forensic
490 [Division of the Connecticut Valley] Hospital for the treatment of
491 persons with psychiatric disabilities or persons with substance use
492 disorders, or both, except the Connecticut Mental Health Center, may
493 have an advisory board appointed by the superintendent or director of
494 the facility for terms to be decided by such superintendent or director.
495 In any case where the present number of members of an advisory
496 board is less than the number of members designated by the
497 superintendent or director of the facility, he shall appoint additional
498 members to such board in accordance with this section in such manner
499 that the terms of an approximately equal number of members shall
500 expire in each odd-numbered year. The superintendent or director
501 shall fill any vacancy that may occur for the unexpired portion of any
502 term. No member may serve more than two successive terms plus the
503 balance of any unexpired term to which he had been appointed. The
504 superintendent or director of the facility shall be an ex-officio member
505 of the advisory board. Each member of an advisory board of a state-
506 operated facility within the Department of Mental Health and
507 Addiction Services assigned a geographical territory shall be a resident
508 of the assigned geographical territory. Members of said advisory
509 boards shall receive no compensation for their services but shall be
510 reimbursed for necessary expenses involved in the performance of
511 their duties. At least one-third of such members shall be from a
512 substance abuse subregional planning and action council established

513 pursuant to section 17a-671, and at least one-third shall be members of
514 the catchment area councils, as provided in section 17a-483, for the
515 catchment areas served by such facility, except that members serving
516 as of October 1, 1977, shall serve out their terms.

517 Sec. 15. Section 17a-471a of the general statutes is repealed and the
518 following is substituted in lieu thereof (*Effective from passage*):

519 (a) The Commissioner of Mental Health and Addiction Services, in
520 consultation and coordination with the advisory council established
521 under subsection (b) of this section, shall develop policies and set
522 standards related to clients residing on the Connecticut Valley
523 Hospital campus and to the discharge of such clients from the hospital
524 into the adjacent community. [Any such policies and standards shall
525 assure that no discharge of any client admitted to Whiting Forensic
526 Division under commitment by the Superior Court or transfer from the
527 Department of Correction shall take place without full compliance
528 with sections 17a-511 to 17a-524, inclusive, 17a-566 to 17a-575,
529 inclusive, 17a-580 to 17a-603, inclusive, and 54-56d.]

530 (b) There is established a Connecticut Valley Hospital Advisory
531 Council that shall advise the Commissioner of Mental Health and
532 Addiction Services on policies concerning, but not limited to, building
533 use, security, clients residing on the campus and the discharge of
534 clients from the [campuses] campus into the adjacent community. In
535 addition, the advisory council shall periodically review the
536 implementation of the policies and standards established by the
537 commissioner in consultation with the advisory council. The council
538 shall be composed of six members appointed by the mayor of
539 Middletown, six members appointed by the Commissioner of Mental
540 Health and Addiction Services and one member who shall serve as
541 chairperson appointed by the Governor.

542 Sec. 16. Section 17a-472 of the general statutes is repealed and the
543 following is substituted in lieu thereof (*Effective from passage*):

544 Except as otherwise provided, the Commissioner of Mental Health

545 and Addiction Services shall appoint and remove (1) the
546 superintendents and directors of state-operated facilities and divisions
547 constituting the Department of Mental Health and Addiction Services,
548 and (2) the director of the Whiting Forensic [Division of Connecticut
549 Valley] Hospital, who shall report to the [director of forensic services]
550 commissioner and shall have as [his] such director's sole responsibility
551 the administration of the Whiting Forensic [Division] Hospital. Each
552 superintendent or director shall be a qualified person with experience
553 in health, hospital or mental health administration.

554 Sec. 17. Section 17a-495 of the general statutes is repealed and the
555 following is substituted in lieu thereof (*Effective from passage*):

556 (a) For the purposes of sections 17a-75 to 17a-83, inclusive, and 17a-
557 615 to 17a-618, inclusive, the following terms shall have the following
558 meanings: "Business day" means Monday to Friday, inclusive, except
559 when a legal holiday falls on any such day; "hospital for psychiatric
560 disabilities" means any public or private hospital, retreat, institution,
561 house or place in which any mentally ill person is received or detained
562 as a patient, but shall not include any correctional institution of this
563 state; "mentally ill person" means any person who has a mental or
564 emotional condition which has substantial adverse effects on his or her
565 ability to function and who requires care and treatment, and
566 specifically excludes a person who is an alcohol-dependent person or a
567 drug-dependent person, as defined in section 17a-680; "patient" means
568 any person detained and taken care of as a mentally ill person; "keeper
569 of a hospital for psychiatric disabilities" means any person, body of
570 persons or corporation which has the immediate superintendence,
571 management and control of a hospital for psychiatric disabilities and
572 the patients therein; "support" includes all necessary food, clothing and
573 medicine and all general expenses of maintaining state hospitals for
574 persons with psychiatric disabilities; "indigent person" means any
575 person who has an estate insufficient, in the judgment of the Court of
576 Probate, to provide for his or her support and has no person or persons
577 legally liable who are able to support him or her; "dangerous to
578 himself or herself or others" means there is a substantial risk that

579 physical harm will be inflicted by an individual upon his or her own
580 person or upon another person, and "gravely disabled" means that a
581 person, as a result of mental or emotional impairment, is in danger of
582 serious harm as a result of an inability or failure to provide for his or
583 her own basic human needs such as essential food, clothing, shelter or
584 safety and that hospital treatment is necessary and available and that
585 such person is mentally incapable of determining whether or not to
586 accept such treatment because his judgment is impaired by his
587 psychiatric disabilities. "Respondent" means a person who is alleged to
588 be mentally ill and for whom an application for commitment to a
589 hospital for persons with psychiatric disabilities has been filed;
590 "voluntary patient" means any patient sixteen years of age or older
591 who applies in writing to and is admitted to a hospital for psychiatric
592 disabilities as a mentally ill person or any patient under sixteen years
593 of age whose parent or legal guardian applies in writing to such
594 hospital for admission of such patient; "involuntary patient" means
595 any patient hospitalized pursuant to an order of a judge of the Probate
596 Court after an appropriate hearing or a patient hospitalized for
597 emergency diagnosis, observation or treatment upon certification of a
598 qualified physician.

599 (b) For the purposes of this section, sections 17a-450 to 17a-484,
600 inclusive, as amended by this act, [17a-495] 71a-496 to 17a-528,
601 inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, and
602 17a-560 to [17a-576] 17a-575, as amended by this act, inclusive, the
603 following terms shall have the following meanings: "Business day"
604 means Monday to Friday, inclusive, except when a legal holiday falls
605 on any such day; "hospital for persons with psychiatric disabilities"
606 means any public or private hospital, retreat, institution, house or
607 place in which any person with psychiatric disabilities is received or
608 detained as a patient, but shall not include any correctional institution
609 of this state; "patient" means any person detained and taken care of as
610 a person with psychiatric disabilities; "keeper of a hospital for persons
611 with psychiatric disabilities" means any person, body of persons or
612 corporation which has the immediate superintendence, management
613 and control of a hospital for persons with psychiatric disabilities and

614 the patients therein; "support" includes all necessary food, clothing and
615 medicine and all general expenses of maintaining state hospitals for
616 persons with psychiatric disabilities; "indigent person" means any
617 person who has an estate insufficient, in the judgment of the Court of
618 Probate, to provide for his or her support and has no person or persons
619 legally liable who are able to support him or her; "dangerous to
620 himself or herself or others" means there is a substantial risk that
621 physical harm will be inflicted by an individual upon his or her own
622 person or upon another person; "gravely disabled" means that a
623 person, as a result of mental or emotional impairment, is in danger of
624 serious harm as a result of an inability or failure to provide for his or
625 her own basic human needs such as essential food, clothing, shelter or
626 safety and that hospital treatment is necessary and available and that
627 such person is mentally incapable of determining whether or not to
628 accept such treatment because his judgment is impaired by his
629 psychiatric disabilities; "respondent" means a person who is alleged to
630 have psychiatric disabilities and for whom an application for
631 commitment to a hospital for persons with psychiatric disabilities has
632 been filed; "voluntary patient" means any patient sixteen years of age
633 or older who applies in writing to and is admitted to a hospital for
634 persons with psychiatric disabilities as a person with psychiatric
635 disabilities or any patient under sixteen years of age whose parent or
636 legal guardian applies in writing to such hospital for admission of such
637 patient; and "involuntary patient" means any patient hospitalized
638 pursuant to an order of a judge of the Probate Court after an
639 appropriate hearing or a patient hospitalized for emergency diagnosis,
640 observation or treatment upon certification of a qualified physician.

641 (c) For the purposes of sections 17a-495 to 17a-528, inclusive, as
642 amended by this act, "person with psychiatric disabilities" means any
643 person who has a mental or emotional condition which has substantial
644 adverse effects on his or her ability to function and who requires care
645 and treatment, and specifically excludes a person who is an alcohol-
646 dependent person or a drug-dependent person, as defined in section
647 17a-680.

648 (d) For the purposes of sections 17a-453 to 17a-454, inclusive, 17a-
649 456, 17a-458 to 17a-464, inclusive, as amended by this act, 17a-466 to
650 17a-469, inclusive, 17a-471, 17a-474, 17a-476 to 17a-484, inclusive, 17a-
651 540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, as amended by
652 this act, inclusive, and 17a-615 to 17a-618, inclusive, "person with
653 psychiatric disabilities" means any person who has a mental or
654 emotional condition which has substantial adverse effects on his or her
655 ability to function and who requires care and treatment, and
656 specifically includes a person who is an alcohol-dependent person or a
657 drug-dependent person, as defined in section 17a-680.

658 Sec. 18. Section 17a-496 of the general statutes is repealed and the
659 following is substituted in lieu thereof (*Effective from passage*):

660 Any keeper of a hospital for psychiatric disabilities who wilfully
661 violates any of the provisions of this section, sections 17a-75 to 17a-83,
662 inclusive, 17a-450 to 17a-484, inclusive, [17a-495] as amended by this
663 act, 17a-497 to 17a-528, inclusive, as amended by this act, 17a-540 to
664 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended
665 by this act, and 17a-615 to 17a-618, inclusive, shall be fined not more
666 than two hundred dollars or imprisoned not more than one year or
667 both.

668 Sec. 19. Subsection (b) of section 17a-497 of the general statutes is
669 repealed and the following is substituted in lieu thereof (*Effective from*
670 *passage*):

671 (b) Upon the motion of any respondent or his or her counsel, or the
672 probate judge having jurisdiction over such application, filed not later
673 than three days prior to any hearing scheduled on such application,
674 the Probate Court Administrator shall appoint a three-judge court
675 from among the probate judges to hear such application. The judge of
676 the Probate Court having jurisdiction over such application under the
677 provisions of this section shall be a member, provided such judge may
678 disqualify himself in which case all three members of such court shall
679 be appointed by the Probate Court Administrator. Such three-judge
680 court when convened shall have all the powers and duties set forth

681 under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive,
682 as amended by this act, 17a-495 to 17a-528, inclusive, as amended by
683 this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575,
684 inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive,
685 and shall be subject to all of the provisions of law as if it were a single-
686 judge court. No such respondent shall be involuntarily confined
687 without the vote of at least two of the three judges convened
688 hereunder. The judges of such court shall designate a chief judge from
689 among their members. All records for any case before the three-judge
690 court shall be maintained in the Probate Court having jurisdiction over
691 the matter as if the three-judge court had not been appointed.

692 Sec. 20. Subsection (g) of section 17a-498 of the general statutes is
693 repealed and the following is substituted in lieu thereof (*Effective from*
694 *passage*):

695 (g) The hospital shall notify each patient at least annually that such
696 patient has a right to a further hearing pursuant to this section. If the
697 patient requests such hearing, it shall be held by the Probate Court for
698 the district in which the hospital is located. Any such request shall be
699 immediately filed with the appropriate court by the hospital. After
700 such request is filed with the Probate Court, it shall proceed in the
701 manner provided in subsections (a), (b), (c) and (f) of this section. In
702 addition, the hospital shall furnish the Probate Court for the district in
703 which the hospital is located on a monthly basis with a list of all
704 patients confined in the hospital involuntarily without release for one
705 year since the last annual review under this section of the patient's
706 commitment or since the original commitment. The hospital shall
707 include in such notification the type of review the patient last received.
708 If the patient's last annual review had a hearing, the Probate Court
709 shall, within fifteen business days thereafter, appoint an impartial
710 physician who is a psychiatrist from the list provided by the
711 Commissioner of Mental Health and Addiction Services as set forth in
712 subsection (c) of this section and not connected with the hospital in
713 which the patient is confined or related by blood or marriage to the
714 original applicant or to the respondent, which physician shall see and

715 examine each such patient within fifteen business days after such
716 physician's appointment and make a report forthwith to such court of
717 the condition of the patient on forms provided by the Probate Court
718 Administrator. If the Probate Court concludes that the confinement of
719 any such patient should be reviewed by such court for possible release
720 of the patient, the court, on its own motion, shall proceed in the
721 manner provided in subsections (a), (b), (c) and (f) of this section,
722 except that the examining physician shall be considered one of the
723 physicians required by subsection (c) of this section. If the patient's last
724 annual review did not result in a hearing, and in any event at least
725 every two years, the Probate Court shall, within fifteen business days,
726 proceed with a hearing in the manner provided in subsections (a), (b),
727 (c) and (f) of this section. All costs and expenses, including Probate
728 Court entry fees provided by statute, in conjunction with the annual
729 psychiatric review and the judicial review under this subsection,
730 except costs for physicians appointed pursuant to this subsection, shall
731 be established by, and paid from funds appropriated to, the Judicial
732 Department, except that if funds have not been included in the budget
733 of the Judicial Department for such costs and expenses, such payment
734 shall be made from the Probate Court Administration Fund.
735 Compensation of any physician appointed to conduct the annual
736 psychiatric review, to examine a patient for any hearing held as a
737 result of such annual review or for any other biennial hearing required
738 pursuant to sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484,
739 inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as
740 amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576]
741 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618,
742 inclusive, shall be paid by the state from funds appropriated to the
743 Department of Mental Health and Addiction Services in accordance
744 with rates established by the Department of Mental Health and
745 Addiction Services.

746 Sec. 21. Section 17a-499 of the general statutes is repealed and the
747 following is substituted in lieu thereof (*Effective from passage*):

748 All proceedings of the Probate Court, upon application made under

749 the provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-
750 484, inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as
751 amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576]
752 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618,
753 inclusive, shall be in writing and filed in such court, and, whenever a
754 court passes an order for the admission of any person to any state
755 hospital for psychiatric disabilities, the court shall record the order and
756 give a certified copy of such order and of the reports of the physicians
757 to the person by whom such person is to be taken to the hospital, as
758 the warrant for such taking and commitment, and shall also forthwith
759 transmit a like copy to the Commissioner of Mental Health and
760 Addiction Services, and, in the case of a person in the custody of the
761 Commissioner of Correction, to the Commissioner of Correction.
762 Whenever a court passes an order for the commitment of any person to
763 any hospital for psychiatric disabilities, it shall, within three business
764 days, provide the Commissioner of Mental Health and Addiction
765 Services with access to identifying information including, but not
766 limited to, name, address, sex, date of birth and date of commitment
767 on all commitments ordered on and after June 1, 1998. All commitment
768 applications, orders of commitment and commitment papers issued by
769 any court in committing persons with psychiatric disabilities to public
770 or private hospitals for psychiatric disabilities shall be in accordance
771 with a form prescribed by the Probate Court Administrator, which
772 form shall be uniform throughout the state. State hospitals and other
773 hospitals for persons with psychiatric disabilities shall, so far as they
774 are able, upon reasonable request of any officer of a court having the
775 power of commitment, send one or more trained attendants or nurses
776 to attend any hearing concerning the commitment of any person with
777 psychiatric disabilities and any such attendant or nurse, when present,
778 shall be designated by the court as the authority to serve commitment
779 process issued under the provisions of sections 17a-75 to 17a-83,
780 inclusive, 17a-450 to 17a-484, inclusive, as amended by this act, 17a-495
781 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550,
782 inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended by this
783 act, and 17a-615 to 17a-618, inclusive.

784 Sec. 22. Subsection (a) of section 17a-500 of the general statutes is
785 repealed and the following is substituted in lieu thereof (*Effective from*
786 *passage*):

787 (a) Each court of probate shall keep a record of the cases relating to
788 persons with psychiatric disabilities coming before it under sections
789 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended
790 by this act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-
791 540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as
792 amended by this act, and 17a-615 to 17a-618, inclusive, and the
793 disposition of them. It shall also keep on file the original application
794 and certificate of physicians required by said sections, or a microfilm
795 duplicate of such records in accordance with regulations issued by the
796 Probate Court Administrator. All records maintained in the courts of
797 probate under the provisions of said sections shall be sealed and
798 available only to the respondent or his or her counsel unless the Court
799 of Probate, after hearing held with notice to the respondent,
800 determines such records should be disclosed for cause shown.

801 Sec. 23. Section 17a-501 of the general statutes is repealed and the
802 following is substituted in lieu thereof (*Effective from passage*):

803 Any person with psychiatric disabilities, the expense of whose
804 support is paid by himself or by another person, may be committed to
805 any institution for the care of persons with psychiatric disabilities
806 designated by the person paying for such support; and any indigent
807 person with psychiatric disabilities, not a pauper, committed under the
808 provisions of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484,
809 inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as
810 amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576]
811 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618,
812 inclusive, shall be committed to any state hospital for psychiatric
813 disabilities which is equipped to receive him, at the discretion of the
814 Court of Probate, upon consideration of a request made by the person
815 applying for such commitment.

816 Sec. 24. Section 17a-504 of the general statutes is repealed and the

817 following is substituted in lieu thereof (*Effective from passage*):

818 Any person who wilfully and maliciously causes, or attempts to
819 cause, or who conspires with any other person to cause, any person
820 who does not have psychiatric disabilities to be committed to any
821 hospital for psychiatric disabilities, and any person who wilfully
822 certifies falsely to the psychiatric disabilities of any person in any
823 certificate provided for in sections 17a-75 to 17a-83, inclusive, 17a-450
824 to 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528,
825 inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560
826 to [17a-576] 17a-575, inclusive, as amended by this act, and 17a-615 to
827 17a-618, inclusive, and any person who, under the provisions of said
828 sections relating to persons with psychiatric disabilities, wilfully
829 reports falsely to any court or judge that any person has psychiatric
830 disabilities, shall be guilty of a class D felony.

831 Sec. 25. Section 17a-505 of the general statutes is repealed and the
832 following is substituted in lieu thereof (*Effective from passage*):

833 When any female with psychiatric disabilities is escorted to a state
834 hospital for persons with psychiatric disabilities by a male guard,
835 attendant or other employee of a correctional or reformatory
836 institution, or by a male law enforcement officer, under the provisions
837 of sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as
838 amended by this act, 17a-495 to 17a-528, inclusive, as amended by this
839 act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575,
840 inclusive, as amended by this act, and 17a-615 to 17a-618, inclusive, the
841 person so escorting her shall be accompanied by an adult member of
842 her family or at least one woman.

843 Sec. 26. Section 17a-517 of the general statutes is repealed and the
844 following is substituted in lieu thereof (*Effective from passage*):

845 [If any] Any person in the custody of the Commissioner of
846 Correction who is brought to a hospital pursuant to the provisions of
847 sections 17a-499, as amended by this act, 17a-509, 17a-512 to [17a-517]
848 17a-516, inclusive, 17a-520, 17a-521, [and] as amended by this act, or

849 54-56d [is a desperate or dangerous individual, such person] shall be
850 hospitalized in the Whiting Forensic [Division] Hospital. If the Whiting
851 Forensic [Division] Hospital is unable to accommodate such transfer,
852 then such person shall remain in the custody of the commissioner at a
853 correctional institution, there confined under appropriate care and
854 supervision. Under no circumstances shall an inmate with psychiatric
855 disabilities requiring maximum security conditions be placed in a state
856 hospital for persons with psychiatric disabilities which does not have
857 the facilities and trained personnel to provide appropriate care and
858 supervision for such individuals.

859 Sec. 27. Section 17a-519 of the general statutes is repealed and the
860 following is substituted in lieu thereof (*Effective from passage*):

861 Each officer or indifferent person making legal service of any order,
862 notice, warrant or other paper under the provisions of sections 17a-75
863 to 17a-83, inclusive, 17a-450 to 17a-484, inclusive, as amended by this
864 act, 17a-495 to 17a-528, inclusive, as amended by this act, 17a-540 to
865 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended
866 by this act, and 17a-615 to 17a-618, inclusive, shall be entitled to the
867 same compensation as is by law provided for like services in civil
868 causes. Physicians, for examining a person alleged to have psychiatric
869 disabilities and making a certificate as provided by said sections, shall
870 be entitled to a reasonable compensation established by the
871 Commissioner of Mental Health and Addiction Services. The fees of
872 the courts of probate shall be such as are provided by law for similar
873 services. The Superior Court, on an appeal, may tax costs at its
874 discretion.

875 Sec. 28. Section 17a-521 of the general statutes is repealed and the
876 following is substituted in lieu thereof (*Effective from passage*):

877 Except as otherwise provided in this section, the superintendent [or
878 keeper] of any institution used wholly or in part for the care of persons
879 with psychiatric disabilities or the director of the Whiting Forensic
880 [Division] Hospital may, under such provisions or agreements as [he]
881 the director deems advisable for psychiatric supervision, permit any

882 patient of the institution under [his] the director's charge temporarily
883 to leave such institution, in charge of his guardian, relatives or friends,
884 or by himself or herself. A person confined to a hospital for psychiatric
885 disabilities under the provisions of section 17a-584 may leave the
886 hospital temporarily as provided under the provisions of section 17a-
887 587. In the case of committed persons, the original order of
888 commitment shall remain in force and effect during absence from the
889 institution either on authorized or unauthorized leave until such
890 patient is officially discharged by the authorities of such institution or
891 such order is superseded by a court of competent jurisdiction. In the
892 case of a patient on authorized leave, if it appears to be for the best
893 interest of the public or for the interest and benefit of such patient, [he]
894 the patient may return or be returned by [his] the patient's guardian,
895 relatives or friends or [he] the patient may be recalled by the
896 authorities of such institution, at any time during such temporary
897 absence and prior to [his] the patient's official discharge. With respect
898 both to patients on authorized and unauthorized leave, state or local
899 police shall, on the request of the authorities of any such institution,
900 assist in the rehospitalization of any patient on temporary leave or of
901 any other patient committed to such institution by a court of
902 competent jurisdiction or any person who is a patient under the
903 provisions of section 17a-502, if, in the opinion of such authorities, the
904 patient's condition warrants such assistance. The expense, if any, of
905 such recall or return shall, in the case of an indigent, be paid by those
906 responsible for [his] the patient's support or, in the case of a pauper, by
907 the state. Leave under this section shall not be available to any person
908 who is under a term of imprisonment or who has not met the
909 requirements of the condition of release set to provide reasonable
910 assurance of such person's appearance in court.

911 Sec. 29. Section 17a-525 of the general statutes is repealed and the
912 following is substituted in lieu thereof (*Effective from passage*):

913 Any person aggrieved by an order, denial or decree of a Probate
914 Court under sections 17a-75 to 17a-83, inclusive, 17a-450 to 17a-484,
915 inclusive, as amended by this act, 17a-495 to 17a-528, inclusive, as

916 amended by this act, 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576]
917 17a-575, inclusive, as amended by this act, and 17a-615 to 17a-618,
918 inclusive, including any relative or friend, on behalf of any person
919 found to have psychiatric disabilities, shall have the right of appeal in
920 accordance with sections 45a-186 to 45a-193, inclusive. On the trial of
921 an appeal, the Superior Court may require the state's attorney or, in the
922 state's attorney's absence, some other practicing attorney of the court to
923 be present for the protection of the interests of the state and of the
924 public.

925 Sec. 30. Subsection (a) of section 17a-528 of the general statutes is
926 repealed and the following is substituted in lieu thereof (*Effective from*
927 *passage*):

928 (a) When any person is found to have psychiatric disabilities, and is
929 committed to a state hospital for psychiatric disabilities, upon
930 proceedings had under sections 17a-75 to 17a-83, inclusive, 17a-450 to
931 17a-484, inclusive, as amended by this act, 17a-495 to 17a-528,
932 inclusive, as amended by this act, 17a-540 to 17a-550, inclusive, 17a-560
933 to [17a-576] 17a-575, inclusive, as amended by this act, and 17a-615 to
934 17a-618, inclusive, all fees and expenses incurred upon the probate
935 commitment proceedings, payment of which is not otherwise provided
936 for under said sections, shall be paid by the state within available
937 appropriations from funds appropriated to the Department of Mental
938 Health and Addiction Services in accordance with rates established by
939 said department; and, if such person is found not to have psychiatric
940 disabilities, such fees and expenses shall be paid by the applicant.

941 Sec. 31. Subsection (a) of section 17a-548 of the general statutes is
942 repealed and the following is substituted in lieu thereof (*Effective from*
943 *passage*):

944 (a) Any patient shall be permitted to wear his or her own clothes; to
945 keep and use personal possessions including toilet articles; [except for
946 patients hospitalized in Whiting Forensic Division;] to be present
947 during any search of his or her personal possessions, except a patient
948 hospitalized in the maximum security service of Whiting Forensic

949 Hospital; to have access to individual storage space for such
950 possessions; and in such manner as determined by the facility to spend
951 a reasonable sum of his or her own money for canteen expenses and
952 small purchases. These rights shall be denied only if the
953 superintendent, director [] or his or her authorized representative
954 determines that it is medically harmful to the patient to exercise such
955 rights. An explanation of such denial shall be placed in the patient's
956 permanent clinical record.

957 Sec. 32. Section 17a-560 of the general statutes is repealed and the
958 following is substituted in lieu thereof (*Effective from passage*):

959 As used in sections 17a-560 to [17a-576] 17a-575, inclusive, as
960 amended by this act, unless specifically provided otherwise,
961 ["division",] "hospital" means the Whiting Forensic [Division] Hospital,
962 including the diagnostic unit established under the provisions of
963 section 17a-562, as amended by this act, or any other facility of the
964 Department of Mental Health and Addiction Services which the
965 commissioner may designate as appropriate. The words ["institute"]
966 "hospital" or "diagnostic unit", as used in sections 17a-566, as amended
967 by this act, 17a-567, as amended by this act, 17a-570, as amended by
968 this act, and [17a-576] 17a-575, as amended by this act, when applied to
969 children or youths under the age of eighteen, mean any facility of the
970 Department of Children and Families designated by the Commissioner
971 of Children and Families. "Board" means the advisory and review
972 board appointed under the provisions of section 17a-565, as amended
973 by this act. "Commissioner" means the Commissioner of Mental Health
974 and Addiction Services or in the case of children, the Commissioner of
975 Children and Families.

976 Sec. 33. Section 17a-561 of the general statutes is repealed and the
977 following is substituted in lieu thereof (*Effective from passage*):

978 The Whiting Forensic [Division of the Connecticut Valley] Hospital
979 shall exist for the care and treatment of (1) patients with psychiatric
980 disabilities, confined in facilities under the control of the Department
981 of Mental Health and Addiction Services, including persons who

982 require care and treatment under maximum security conditions, (2)
983 persons convicted of any offense enumerated in section 17a-566, as
984 amended by this act, who, after examination by the staff of the
985 diagnostic unit of the [division] hospital as herein provided, are
986 determined to have psychiatric disabilities and be dangerous to
987 themselves or others and to require custody, care and treatment at the
988 [division and] hospital, (3) inmates in the custody of the Commissioner
989 of Correction who are transferred in accordance with sections 17a-512
990 to 17a-517, inclusive, as amended by this act, and who require custody,
991 care and treatment at the [division] hospital, and (4) persons
992 committed to the hospital pursuant to section 17a-582 or 54-56d.

993 Sec. 34. Section 17a-562 of the general statutes is repealed and the
994 following is substituted in lieu thereof (*Effective from passage*):

995 The Whiting Forensic [Division of the Connecticut Valley] Hospital
996 shall be within the general administrative control and supervision of
997 the Department of Mental Health and Addiction Services. The director,
998 with the approval of the commissioner and the board, shall establish
999 such [subdivisions] divisions, which may be located geographically
1000 separate from the [division] hospital, as may be deemed proper for the
1001 administrative control and the efficient operation thereof, one of which
1002 [subdivisions] divisions shall be the diagnostic unit.

1003 Sec. 35. Section 17a-564 of the general statutes is repealed and the
1004 following is substituted in lieu thereof (*Effective from passage*):

1005 The director of the Whiting Forensic [Division] Hospital shall
1006 quarterly make a report to the Board of Mental Health and Addiction
1007 Services on the affairs of the [division] hospital, including reports of
1008 reexaminations and recommendations.

1009 Sec. 36. Section 17a-565 of the general statutes is repealed and the
1010 following is substituted in lieu thereof (*Effective from passage*):

1011 (a) There shall be an advisory board for the [division] Whiting
1012 Forensic Hospital, constituted as follows: The Commissioner of Mental

1013 Health and Addiction Services, three physicians licensed to practice in
1014 this state, two of whom shall be psychiatrists, two attorneys of this
1015 state, at least one of whom shall be in active practice and have at least
1016 five years' experience in the trial of criminal cases, one licensed
1017 psychologist with experience in clinical psychology, one licensed
1018 clinical social worker, and one person actively engaged in business
1019 who shall have at least ten years' experience in business management.
1020 Annually, on October first, the Governor shall appoint a member or
1021 members to replace those whose terms expire for terms of five years
1022 each. The board shall elect a chairman and a secretary, who shall keep
1023 full and accurate minutes of its meetings and preserve the same. The
1024 board shall meet at the call of the chairman at least quarterly. Members
1025 of the board shall receive no compensation for their duties as such but
1026 shall be reimbursed for their actual expenses incurred in the course of
1027 their duties. Said board shall confer with the staff of the [division]
1028 hospital and give general consultative and advisory services on
1029 problems and matters relating to its work. On any matter relating to
1030 the work of the [division] hospital, the board may also confer with the
1031 warden or superintendent of the affected Connecticut correctional
1032 institution.

1033 (b) The advisory board shall develop policies and set standards
1034 related to clients residing in Whiting Forensic Hospital. Such policies
1035 and standards shall ensure that no discharge of any client admitted to
1036 said hospital under commitment by the Superior Court or transfer
1037 from the Department of Correction shall take place without full
1038 compliance with sections 17a-511 to 17a-524, inclusive, 17a-566 to 17a-
1039 575, inclusive, as amended by this act, 17a-580 to 17a-603, inclusive,
1040 and 54-56d.

1041 Sec. 37. Section 17a-566 of the general statutes is repealed and the
1042 following is substituted in lieu thereof (*Effective from passage*):

1043 (a) Except as provided in section 17a-574, as amended by this act,
1044 any court prior to sentencing a person convicted of an offense for
1045 which the penalty may be imprisonment in the Connecticut

1046 Correctional Institution at Somers, or of a sex offense involving (1)
1047 physical force or violence, (2) disparity of age between an adult and a
1048 minor or (3) a sexual act of a compulsive or repetitive nature, may if it
1049 appears to the court that such person has psychiatric disabilities and is
1050 dangerous to himself or others, upon its own motion or upon request
1051 of any of the persons enumerated in subsection (b) of this section and a
1052 subsequent finding that such request is justified, order the
1053 commissioner to conduct an examination of the convicted defendant
1054 by qualified personnel of the [division] hospital. Upon completion of
1055 such examination the examiner shall report in writing to the court.
1056 Such report shall indicate whether the convicted defendant should be
1057 committed to the diagnostic unit of the [division] hospital for
1058 additional examination or should be sentenced in accordance with the
1059 conviction. Such examination shall be conducted and the report made
1060 to the court not later than fifteen days after the order for the
1061 examination. Such examination may be conducted at a correctional
1062 facility if the defendant is confined or it may be conducted on an
1063 outpatient basis at the [division] hospital or other appropriate location.
1064 If the report recommends additional examination at the diagnostic
1065 unit, the court may, after a hearing, order the convicted defendant
1066 committed to the diagnostic unit of the [division] hospital for a period
1067 not to exceed sixty days, except as provided in section 17a-567, as
1068 amended by this act, provided the hearing may be waived by the
1069 defendant. Such commitment shall not be effective until the director
1070 certifies to the court that space is available at the diagnostic unit. While
1071 confined in said diagnostic unit, the defendant shall be given a
1072 complete physical and psychiatric examination by the staff of the unit
1073 and may receive medication and treatment without his consent. The
1074 director shall have authority to procure all court records, institutional
1075 records and probation or other reports which provide information
1076 about the defendant.

1077 (b) The request for such examination may be made by the state's
1078 attorney or assistant state's attorney who prosecuted the defendant for
1079 an offense specified in this section, or by the defendant or his attorney
1080 in his behalf. If the court orders such examination, a copy of the

1081 examination order shall be served upon the defendant to be examined.

1082 (c) Upon completion of the physical and psychiatric examination of
1083 the defendant, but not later than sixty days after admission to the
1084 diagnostic unit, a written report of the results thereof shall be filed in
1085 quadruplicate with the clerk of the court before which he was
1086 convicted, and such clerk shall cause copies to be delivered to the
1087 state's attorney, to counsel for the defendant and to the Court Support
1088 Services Division.

1089 (d) Such report shall include the following: (1) A description of the
1090 nature of the examination; (2) a diagnosis of the mental condition of
1091 the defendant; (3) an opinion as to whether the diagnosis and
1092 prognosis demonstrate clearly that the defendant is actually dangerous
1093 to himself or others and requires custody, care and treatment at the
1094 [division] hospital; and (4) a recommendation as to whether the
1095 defendant should be sentenced in accordance with the conviction,
1096 sentenced in accordance with the conviction and confined in the
1097 [institute] hospital for custody, care and treatment, placed on
1098 probation by the court or placed on probation by the court with the
1099 requirement, as a condition to probation, that he receive outpatient
1100 psychiatric treatment.

1101 Sec. 38. Section 17a-567 of the general statutes is repealed and the
1102 following is substituted in lieu thereof (*Effective from passage*):

1103 (a) If the report recommends that the defendant be sentenced in
1104 accordance with the conviction, placed on probation by the court or
1105 placed on probation by the court with the requirement, as a condition
1106 of such probation, that he receive outpatient psychiatric treatment, the
1107 defendant shall be returned directly to the court for disposition. If the
1108 report recommends sentencing in accordance with the conviction and
1109 confinement in the [division] hospital for custody, care and treatment,
1110 then during the period between the submission of the report and the
1111 disposition of the defendant by the court such defendant shall remain
1112 at the [division] hospital and may receive such custody, care and
1113 treatment as is consistent with his medical needs.

1114 (b) If the report recommends confinement at the [division] hospital
1115 for custody, care and treatment, the court shall set the matter for a
1116 hearing not later than fifteen days after receipt of the report. Any
1117 evidence, including the report ordered by the court, regarding the
1118 defendant's mental condition may be introduced at the hearing by
1119 either party. Any staff member of the diagnostic unit who participated
1120 in the examination of the defendant and who signed the report may
1121 testify as to the contents of the report. The defendant may waive the
1122 court hearing.

1123 (c) If at such hearing the court finds the defendant is not in need of
1124 custody, care and treatment at the [division] hospital, it shall sentence
1125 [him] the defendant in accordance with the conviction or place [him]
1126 the defendant on probation. If the court finds that [such person] the
1127 defendant is in need of outpatient psychiatric treatment, it may place
1128 [him] the defendant on probation on condition that [he] the defendant
1129 receive such treatment. If the court finds [such person] the defendant
1130 to have psychiatric disabilities and to be dangerous to himself, herself
1131 or others and to require custody, care and treatment at the [division]
1132 hospital, it shall sentence [him] the defendant in accordance with the
1133 conviction and order confinement in the [division] hospital for
1134 custody, care and treatment provided no court may order such
1135 confinement if the report does not recommend confinement at the
1136 [division] hospital. The defendant shall not be subject to custody, care
1137 and treatment under sections 17a-560 to [17a-576] 17a-575, inclusive, as
1138 amended by this act, beyond the maximum period specified in the
1139 sentence.

1140 Sec. 39. Section 17a-568 of the general statutes is repealed and the
1141 following is substituted in lieu thereof (*Effective from passage*):

1142 Nothing in sections 17a-560 to [17a-576] 17a-575, inclusive, as
1143 amended by this act, shall affect proceedings under sections 17a-580 to
1144 17a-602, inclusive, 17b-250 and 54-56d.

1145 Sec. 40. Section 17a-569 of the general statutes is repealed and the
1146 following is substituted in lieu thereof (*Effective from passage*):

1147 Not less than once every six months the staff of the [institute]
1148 hospital shall give a complete psychiatric examination to every patient
1149 confined in the [division] hospital. As used in this section and sections
1150 17a-570 to 17a-573, inclusive, as amended by this act, the word
1151 "patient" means any person confined for custody, care and treatment
1152 under section 17a-567, as amended by this act. Such examination shall
1153 ascertain whether the patient has psychiatric disabilities and is in need
1154 of custody, care and treatment at the [division] hospital and, in making
1155 such determination, the staff shall assemble such information and
1156 follow such procedures as are used in initial examinations by the
1157 diagnostic unit to indicate the need for custody, care and treatment.
1158 The record of the examination shall include the information required
1159 in subdivisions (1), (2) and (3) of subsection (d) of section 17a-566, as
1160 amended by this act, and a recommendation for the future treatment of
1161 the patient examined. The record of the examination may include a
1162 recommendation for transfer of the patient or change in confinement
1163 status.

1164 Sec. 41. Section 17a-570 of the general statutes is repealed and the
1165 following is substituted in lieu thereof (*Effective from passage*):

1166 (a) As soon as is practicable, the director of the Whiting Forensic
1167 [Division] Hospital shall act upon the examination reports of the
1168 director's staff. Upon review of each report and upon consideration of
1169 what is for the benefit of the patient and for the benefit of society, the
1170 director shall determine whether such patient: (1) Is to remain in the
1171 [division] hospital for further treatment, or (2) has sufficiently
1172 improved to warrant discharge from the [division] hospital, provided
1173 if such patient was sentenced and confined in the [division] hospital
1174 under section 17a-567, as amended by this act, such patient shall not be
1175 released except upon order of the court by which such patient was
1176 confined under said section, after notice to said court by the director.
1177 The director shall report each determination made under this
1178 subsection to the court by which the patient was confined in the
1179 [division] hospital.

1180 (b) If a report submitted by the director to the court under
1181 subsection (a) of this section recommends that the patient be returned
1182 to the custody of the Commissioner of Correction, the court shall set
1183 the matter for a hearing not later than fifteen days after receipt of such
1184 report.

1185 (c) The court, upon its own motion or at the request of the patient or
1186 the patient's attorney, may at any time hold a hearing to determine
1187 whether such patient should be discharged from the [division] hospital
1188 prior to the expiration of the maximum period of the patient's
1189 sentence. Prior to such hearing, the [division] hospital shall file a
1190 report with the court concerning the patient's mental condition. The
1191 court may appoint a physician specializing in psychiatry to examine
1192 the patient and report to the court. Such hearing shall be held at least
1193 once every five years. If the court determines that the patient should be
1194 discharged from the [division] hospital, the patient shall be returned to
1195 the custody of the Commissioner of Correction.

1196 Sec. 42. Section 17a-572 of the general statutes is repealed and the
1197 following is substituted in lieu thereof (*Effective from passage*):

1198 All certificates, applications, records and reports made for the
1199 purpose of sections 17a-560 to [17a-576] 17a-575, inclusive, as amended
1200 by this act, and directly or indirectly identifying a person subject to it
1201 shall be kept confidential and shall not be disclosed by any person
1202 except so far (1) as the individual identified or his legal guardian, if
1203 any, or, if he is a minor, his parent or legal guardian, consents or (2) as
1204 disclosure may be necessary to carry out any of the provisions of said
1205 sections or (3) as a court may direct upon its determination that
1206 disclosure is necessary for the conduct of proceedings before it and
1207 that failure to make such disclosure would be contrary to the public
1208 interest.

1209 Sec. 43. Section 17a-573 of the general statutes is repealed and the
1210 following is substituted in lieu thereof (*Effective from passage*):

1211 Within two months prior to the expiration of the maximum term of

1212 confinement authorized for any patient under section 17a-567, as
1213 amended by this act, the director of the [division] hospital may, upon
1214 the recommendation of the board, initiate proceedings under section
1215 17a-497 or 17a-520, as amended by this act, for the commitment or
1216 further commitment, as the case may be, of the patient.

1217 Sec. 44. Section 17a-574 of the general statutes is repealed and the
1218 following is substituted in lieu thereof (*Effective from passage*):

1219 Nothing in sections 17a-560 to [17a-576] 17a-575, inclusive, as
1220 amended by this act, shall be construed to extend to or affect any case
1221 in the Superior Court involving a juvenile matter, or to any person
1222 arrested for an offense which is not punishable by imprisonment for
1223 more than one year or by a fine of not more than one thousand dollars
1224 or both or except as provided in section 46b-127.

1225 Sec. 45. Section 17a-575 of the general statutes is repealed and the
1226 following is substituted in lieu thereof (*Effective from passage*):

1227 Nothing in sections 17a-560 to [17a-576] 17a-575, inclusive, as
1228 amended by this act, shall be construed to limit or suspend the writ of
1229 habeas corpus.

1230 Sec. 46. Subsection (d) of section 45a-656 of the 2018 supplement to
1231 the general statutes is repealed and the following is substituted in lieu
1232 thereof (*Effective from passage*):

1233 (d) The conservator of the person shall not have the power or
1234 authority to cause the respondent to be committed to any institution
1235 for the treatment of the mentally ill except under the provisions of
1236 sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-484, inclusive, 17a-
1237 495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550,
1238 inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended by this
1239 act, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-664, inclusive, and
1240 chapter 359.

1241 Sec. 47. Subsection (d) of section 45a-656 of the 2018 supplement to
1242 the general statutes, as amended by section 4 of public act 17-7, is

1243 repealed and the following is substituted in lieu thereof (*Effective July*
1244 *1, 2018*):

1245 (d) The conservator of the person shall not have the power or
1246 authority to cause the respondent to be committed to any institution
1247 for the treatment of the mentally ill except under the provisions of
1248 sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-484, inclusive, 17a-
1249 495 to 17a-528, inclusive, as amended by this act, 17a-540 to 17a-550,
1250 inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as amended by this
1251 act, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-664, inclusive, and
1252 chapter 359.

1253 Sec. 48. Subsection (e) of section 45a-677 of the 2018 supplement to
1254 the general statutes is repealed and the following is substituted in lieu
1255 thereof (*Effective from passage*):

1256 (e) A plenary guardian or limited guardian shall not have the power
1257 or authority: (1) To cause the protected person to be admitted to any
1258 institution for treatment of the mentally ill, except in accordance with
1259 the provisions of sections 17a-75 to 17a-83, inclusive, 17a-456 to 17a-
1260 484, inclusive, 17a-495 to 17a-528, inclusive, as amended by this act,
1261 17a-540 to 17a-550, inclusive, 17a-560 to [17a-576] 17a-575, inclusive, as
1262 amended by this act, 17a-615 to 17a-618, inclusive, and 17a-621 to 17a-
1263 664, inclusive, and chapter 420b; (2) to cause the protected person to be
1264 admitted to any training school or other facility provided for the care
1265 and training of persons with intellectual disability if there is a conflict
1266 concerning such admission between the guardian and the protected
1267 person or next of kin, except in accordance with the provisions of
1268 sections 17a-274 and 17a-275; (3) to consent on behalf of the protected
1269 person to a sterilization, except in accordance with the provisions of
1270 sections 45a-690 to 45a-700, inclusive; (4) to consent on behalf of the
1271 protected person to psychosurgery, except in accordance with the
1272 provisions of section 17a-543; (5) to consent on behalf of the protected
1273 person to the termination of the protected person's parental rights,
1274 except in accordance with the provisions of sections 45a-706 to 45a-709,
1275 inclusive, 45a-715 to 45a-718, inclusive, 45a-724 to 45a-737, inclusive,

1276 and 45a-743 to 45a-757, inclusive; (6) to consent on behalf of the
1277 protected person to the performance of any experimental biomedical
1278 or behavioral medical procedure or participation in any biomedical or
1279 behavioral experiment, unless it (A) is intended to preserve the life or
1280 prevent serious impairment of the physical health of the protected
1281 person, (B) is intended to assist the protected person to regain the
1282 protected person's abilities and has been approved for the protected
1283 person by the court, or (C) has been (i) approved by a recognized
1284 institutional review board, as defined by 45 CFR 46, 21 CFR 50 and 21
1285 CFR 56, as amended from time to time, which is not a part of the
1286 Department of Developmental Services, (ii) endorsed or supported by
1287 the Department of Developmental Services, and (iii) approved for the
1288 protected person by such protected person's primary care physician;
1289 (7) to admit the protected person to any residential facility operated by
1290 an organization by whom such guardian is employed, except in
1291 accordance with the provisions of section 17a-274; (8) to prohibit the
1292 marriage or divorce of the protected person; and (9) to consent on
1293 behalf of the protected person to an abortion or removal of a body
1294 organ, except in accordance with applicable statutory procedures
1295 when necessary to preserve the life or prevent serious impairment of
1296 the physical or mental health of the protected person.

1297 Sec. 49. Section 18-101f of the general statutes is repealed and the
1298 following is substituted in lieu thereof (*Effective from passage*):

1299 A personnel or medical file or similar file concerning a current or
1300 former employee of the Division of Public Defender Services,
1301 Department of Correction or the Department of Mental Health and
1302 Addiction Services, including, but not limited to, a record of a security
1303 investigation of such employee by the department or division or an
1304 investigation by the department or division of a discrimination
1305 complaint by or against such employee, shall not be subject to
1306 disclosure under the Freedom of Information Act, as defined in section
1307 1-200, to any individual committed to the custody or supervision of the
1308 Commissioner of Correction or confined in a facility of the Whiting
1309 Forensic [Division of the Connecticut Valley] Hospital. For the

1310 purposes of this section, an "employee of the Department of
1311 Correction" includes a member or employee of the Board of Pardons
1312 and Paroles within the Department of Correction.

1313 Sec. 50. Subsection (a) of section 46a-152 of the 2018 supplement to
1314 the general statutes is repealed and the following is substituted in lieu
1315 thereof (*Effective from passage*):

1316 (a) No provider or assistant may use involuntary physical restraint
1317 on a person at risk except (1) as an emergency intervention to prevent
1318 immediate or imminent injury to the person at risk or to others,
1319 provided the restraint is not used for discipline or convenience and is
1320 not used as a substitute for a less restrictive alternative, (2) as
1321 necessary and appropriate, as determined on an individual basis by
1322 the person's treatment team and consistent with sections 17a-540 to
1323 17a-550, inclusive, for the transportation of a person under the
1324 jurisdiction of the Whiting Forensic [Division] Hospital of the
1325 Department of Mental Health and Addiction Services.

1326 Sec. 51. Subsection (a) of section 12-19a of the general statutes is
1327 repealed and the following is substituted in lieu thereof (*Effective from*
1328 *passage*):

1329 (a) Until the fiscal year commencing July 1, 2016, on or before
1330 January first, annually, the Secretary of the Office of Policy and
1331 Management shall determine the amount due, as a state grant in lieu of
1332 taxes, to each town in this state wherein state-owned real property,
1333 reservation land held in trust by the state for an Indian tribe, a
1334 municipally owned airport, or any airport owned by the Connecticut
1335 Airport Authority, other than Bradley International Airport, except
1336 that which was acquired and used for highways and bridges, but not
1337 excepting property acquired and used for highway administration or
1338 maintenance purposes, is located. The grant payable to any town
1339 under the provisions of this section in the state fiscal year commencing
1340 July 1, 1999, and each fiscal year thereafter, shall be equal to the total of
1341 (1) (A) one hundred per cent of the property taxes which would have
1342 been paid with respect to any facility designated by the Commissioner

1343 of Correction, on or before August first of each year, to be a
1344 correctional facility administered under the auspices of the
1345 Department of Correction or a juvenile detention center under
1346 direction of the Department of Children and Families that was used for
1347 incarcerative purposes during the preceding fiscal year. If a list
1348 containing the name and location of such designated facilities and
1349 information concerning their use for purposes of incarceration during
1350 the preceding fiscal year is not available from the Secretary of the State
1351 on the first day of August of any year, said commissioner shall, on said
1352 first day of August, certify to the Secretary of the Office of Policy and
1353 Management a list containing such information, (B) one hundred per
1354 cent of the property taxes which would have been paid with respect to
1355 that portion of the John Dempsey Hospital located at The University of
1356 Connecticut Health Center in Farmington that is used as a permanent
1357 medical ward for prisoners under the custody of the Department of
1358 Correction. Nothing in this section shall be construed as designating
1359 any portion of The University of Connecticut Health Center John
1360 Dempsey Hospital as a correctional facility, and (C) in the state fiscal
1361 year commencing July 1, 2001, and each fiscal year thereafter, one
1362 hundred per cent of the property taxes which would have been paid
1363 on any land designated within the 1983 Settlement boundary and
1364 taken into trust by the federal government for the Mashantucket
1365 Pequot Tribal Nation on or after June 8, 1999, (2) subject to the
1366 provisions of subsection (c) of this section, sixty-five per cent of the
1367 property taxes which would have been paid with respect to the
1368 buildings and grounds comprising Connecticut Valley Hospital and
1369 Whiting Forensic Hospital in Middletown. Such grant shall commence
1370 with the fiscal year beginning July 1, 2000, and continuing each year
1371 thereafter, (3) notwithstanding the provisions of subsections (b) and (c)
1372 of this section, with respect to any town in which more than fifty per
1373 cent of the property is state-owned real property, one hundred per cent
1374 of the property taxes which would have been paid with respect to such
1375 state-owned property. Such grant shall commence with the fiscal year
1376 beginning July 1, 1997, and continuing each year thereafter, (4) subject
1377 to the provisions of subsection (c) of this section, forty-five per cent of

1378 the property taxes which would have been paid with respect to all
1379 other state-owned real property, (5) forty-five per cent of the property
1380 taxes which would have been paid with respect to all municipally
1381 owned airports or any airport owned by the Connecticut Airport
1382 Authority, other than Bradley International Airport, except for the
1383 exemption applicable to such property, on the assessment list in such
1384 town for the assessment date two years prior to the commencement of
1385 the state fiscal year in which such grant is payable. The grant provided
1386 pursuant to this section for any municipally owned airport or any
1387 airport owned by the Connecticut Airport Authority, other than
1388 Bradley International Airport, shall be paid to any municipality in
1389 which the airport is located, except that the grant applicable to
1390 Sikorsky Airport shall be paid half to the town of Stratford and half to
1391 the city of Bridgeport, and (6) forty-five per cent of the property taxes
1392 which would have been paid with respect to any land designated
1393 within the 1983 Settlement boundary and taken into trust by the
1394 federal government for the Mashantucket Pequot Tribal Nation prior
1395 to June 8, 1999, or taken into trust by the federal government for the
1396 Mohegan Tribe of Indians of Connecticut, provided (A) the real
1397 property subject to this subdivision shall be the land only, and shall
1398 not include the assessed value of any structures, buildings or other
1399 improvements on such land, and (B) said forty-five per cent grant shall
1400 be phased in as follows: (i) In the fiscal year commencing July 1, 2012,
1401 an amount equal to ten per cent of said forty-five per cent grant, (ii) in
1402 the fiscal year commencing July 1, 2013, thirty-five per cent of said
1403 forty-five per cent grant, (iii) in the fiscal year commencing July 1,
1404 2014, sixty per cent of said forty-five per cent grant, (iv) in the fiscal
1405 year commencing July 1, 2015, eighty-five per cent of said forty-five
1406 per cent grant, and (v) in the fiscal year commencing July 1, 2016, one
1407 hundred per cent of said forty-five per cent grant.

1408 Sec. 52. Subparagraph (D) of subdivision (1) of subsection (b) of
1409 section 12-18b of the general statutes is repealed and the following is
1410 substituted in lieu thereof (*Effective from passage*):

1411 (D) Subject to the provisions of subsection (c) of section 12-19a,

1412 sixty-five per cent of the property taxes that would have been paid
1413 with respect to the buildings and grounds comprising Connecticut
1414 Valley Hospital and Whiting Forensic Hospital in Middletown;

1415 Sec. 53. (NEW) (*Effective October 1, 2018*) (a) As used in this section
1416 and section 54 of this act:

1417 (1) "Abuse" means the wilful infliction of physical pain, injury or
1418 mental anguish, or the wilful deprivation by a caregiver of services
1419 which are necessary to maintain the physical and mental health of a
1420 patient;

1421 (2) "Behavioral health facility" means any facility operated by the
1422 Department of Mental Health and Addiction Services that provides
1423 mental health or substance use disorder services to persons eighteen
1424 years of age or older;

1425 (3) "Patient" means any person receiving services from a behavioral
1426 health facility;

1427 (4) "Legal representative" means a court-appointed fiduciary,
1428 including a guardian or conservator, or a person with power of
1429 attorney authorized to act on a patient's behalf; and

1430 (5) "Mandatory reporter" means (A) any person in a behavioral
1431 health facility paid to provide direct care for a patient of such facility,
1432 and (B) any employee, contractor or consultant of such facility who is a
1433 licensed healthcare provider.

1434 (b) Any mandatory reporter, who, in the ordinary course of such
1435 person's employment, has reasonable cause to suspect or believe that
1436 any patient (1) has been abused, (2) is in a condition that is the result of
1437 abuse, or (3) has had an injury that is at variance with the history given
1438 of such injury, shall, not later than seventy-two hours after such
1439 suspicion or belief arose, report such information or cause a report to
1440 be made in any reasonable manner to the Commissioner of Mental
1441 Health and Addiction Services or to the person or persons designated
1442 by the commissioner to receive such reports. Any behavioral health

1443 facility providing direct care for patients shall provide mandatory
1444 training on detecting potential abuse of patients to mandatory
1445 reporters and inform such individuals of their obligations under this
1446 section.

1447 (c) Any mandatory reporter who fails to make a report under
1448 subsection (b) of this section or fails to make such report within the
1449 prescribed time period set forth in said subsection shall be fined not
1450 more than five hundred dollars, except if such person intentionally
1451 fails to make such report within the prescribed time period, such
1452 person shall be guilty of (1) a class C misdemeanor for the first
1453 violation, and (2) a class A misdemeanor for any subsequent violation.

1454 (d) A report made under subsection (b) of this section shall contain
1455 the name and address of the behavioral health facility, the name of the
1456 patient, information regarding the nature and extent of the abuse and
1457 any other information the mandatory reporter believes may be helpful
1458 in an investigation of the case and for the protection of the patient.

1459 (e) Any other person having reasonable cause to believe that a
1460 patient is being or has been abused shall report such information in
1461 accordance with subsection (b) of this section in any reasonable
1462 manner to the Commissioner of Mental Health and Addiction Services,
1463 or to the person or persons designated by the commissioner to receive
1464 such reports, who shall inform the patient or such patient's legal
1465 representative of the services of the nonprofit entity designated by the
1466 Governor in accordance with section 46a-10b of the general statutes to
1467 serve as the Connecticut protection and advocacy system.

1468 (f) A report filed under this section shall not be deemed a public
1469 record, and shall not be subject to the provisions of section 1-210 of the
1470 general statutes, as amended by this act. Information derived from
1471 such report for which reasonable grounds are determined to exist after
1472 investigation, including the identity of the behavioral health facility,
1473 the number of complaints received, the number of complaints
1474 substantiated and the types of complaints, may be disclosed by the
1475 Commissioner of Mental Health and Addiction Services, except in no

1476 case shall the name of the patient be revealed, unless such person
1477 specifically requests such disclosure or unless a judicial proceeding
1478 results from such report. Notwithstanding the provisions of this
1479 section, not later than twenty-four hours or as soon as possible after
1480 receiving a report under this section, the commissioner or the
1481 commissioner's designee shall notify such person's legal
1482 representative, if any. Such notification shall not be required when the
1483 legal representative is suspected of perpetrating the abuse that is the
1484 subject of the report. The commissioner shall obtain the contact
1485 information for such legal representative from the behavioral health
1486 facility.

1487 (g) (1) Subject to subdivision (2) of this subsection, any person who
1488 makes a report under this section or who testifies in any administrative
1489 or judicial proceeding arising from the report shall be immune from
1490 any civil or criminal liability with regard to such report or testimony,
1491 except liability for perjury in the context of making such report.

1492 (2) Any person who makes a report under this section is guilty of
1493 making a fraudulent or malicious report or providing false testimony
1494 when such person (A) wilfully makes a fraudulent or malicious report,
1495 (B) conspires with another person to make or cause to be made such
1496 fraudulent or malicious report, or (C) wilfully testifies falsely in any
1497 administrative or judicial proceeding arising from such report
1498 regarding the abuse of a patient. Making a fraudulent or malicious
1499 report or providing false testimony under this section is a class A
1500 misdemeanor.

1501 (h) Any person who is discharged or in any manner discriminated
1502 or retaliated against for making, in good faith, a report under this
1503 section shall be entitled to all remedies available under law.

1504 Sec. 54. (NEW) (*Effective October 1, 2018*) (a) The Commissioner of
1505 Mental Health and Addiction Services, upon receiving a report under
1506 section 53 of this act that a patient is being or has been abused, shall
1507 investigate the report to determine the condition of the patient and
1508 what action and services, if any, are required. The investigation shall

1509 include (1) an in-person visit to the named patient, (2) consultation
1510 with those individuals having knowledge of the facts surrounding the
1511 particular report, and (3) an interview with the patient, unless the
1512 patient refuses to consent to such interview. Upon completion of the
1513 investigation, the commissioner shall prepare written findings that
1514 shall include recommended actions. Not later than forty-five days after
1515 completion of the investigation, the commissioner shall disclose, in
1516 general terms, the result of the investigation to the person or persons
1517 who reported the suspected abuse, provided: (A) The person who
1518 made such report is legally mandated to make such report, (B) the
1519 information is not otherwise privileged or confidential under state or
1520 federal law, (C) the names of the witnesses or other persons
1521 interviewed are kept confidential, and (D) the names of the person or
1522 persons suspected to be responsible for the abuse are not disclosed
1523 unless such person or persons have been arrested as a result of the
1524 investigation.

1525 (b) The Department of Mental Health and Addiction Services shall
1526 maintain a state-wide registry of the number of reports received under
1527 this section, the allegations contained in such reports and the outcomes
1528 of the investigations resulting from such reports.

1529 (c) The patient's file, including, but not limited to, the original report
1530 and the investigation report shall not be deemed a public record or
1531 subject to the provisions of section 1-210 of the general statutes, as
1532 amended by this act. The commissioner may disclose such file, in
1533 whole or in part, to an individual, agency, corporation or organization
1534 only with the written authorization of the patient, the patient's legal
1535 representative or as otherwise authorized under this section.

1536 (d) Notwithstanding the provisions of subsection (c) of this section,
1537 the commissioner shall not disclose the name of a person who reported
1538 suspected abuse, except with such person's written permission or to a
1539 law enforcement official pursuant to a court order that specifically
1540 requires such disclosure.

1541 (e) The patient or such patient's legal representative or attorney

1542 shall have the right of access to records made, maintained or kept on
1543 file by the department, in accordance with all applicable state and
1544 federal law, when such records pertain to or contain information or
1545 material concerning the patient, including, but not limited to, records
1546 concerning investigations, reports or medical, psychological or
1547 psychiatric examinations of the patient, except: (1) If protected health
1548 information was obtained by the department from someone other than
1549 a health care provider under the promise of confidentiality and the
1550 access requested would, with reasonable likelihood, reveal the source
1551 of the information; (2) information identifying the individual who
1552 reported the abuse of the person shall not be released unless, upon
1553 application made to the Superior Court by the patient or such patient's
1554 legal representative or attorney and served on the Commissioner of
1555 Mental Health and Addiction Services, a judge determines, after in
1556 camera inspection of relevant records and a hearing, that there is
1557 reasonable cause to believe the individual knowingly made a false
1558 report or that other interests of justice require such release; (3) if it is
1559 determined by a licensed health care provider that the access requested
1560 is reasonably likely to endanger the life or physical safety of the patient
1561 or another person; (4) if the protected health information makes
1562 reference to another person, other than a health care provider, and the
1563 access requested would reveal protected health information about such
1564 other person; or (5) the request for access is made by the patient's legal
1565 representative, and a licensed health care provider has determined, in
1566 the exercise of professional judgment, that the provision of access to
1567 such legal representative is reasonably likely to cause harm to the
1568 patient or another person.

1569 Sec. 55. Section 19a-754a of the 2018 supplement to the general
1570 statutes is repealed and the following is substituted in lieu thereof
1571 (*Effective July 1, 2018*):

1572 (a) There is established an Office of Health Strategy, which shall be
1573 within the Department of Public Health for administrative purposes
1574 only. The department head of said office shall be the executive director
1575 of the Office of Health Strategy, who shall be appointed by the

1576 Governor in accordance with the provisions of sections 4-5 to 4-8,
1577 inclusive, as amended by this act, with the powers and duties therein
1578 prescribed.

1579 (b) [On or before July 1, 2018, the] The Office of Health Strategy
1580 shall be responsible for the following:

1581 (1) Developing and implementing a comprehensive and cohesive
1582 health care vision for the state, including, but not limited to, a
1583 coordinated state health care cost containment strategy;

1584 (2) Promoting effective health planning and the provision of quality
1585 health care in the state in a manner that ensures access for all state
1586 residents to cost-effective health care services, avoids the duplication
1587 of such services and improves the availability and financial stability of
1588 such services throughout the state;

1589 [(2)] (3) Directing and overseeing [(A) the all-payers claims database
1590 program established pursuant to section 19a-755a, and (B)] the State
1591 Innovation Model Initiative and related successor initiatives;

1592 [(3)] (4) (A) Coordinating the state's health information technology
1593 initiatives, (B) seeking funding for and overseeing the planning,
1594 implementation and development of policies and procedures for the
1595 administration of the all-payer claims database program established
1596 under section 19a-775a, as amended by this act, (C) establishing and
1597 maintaining a consumer health information Internet web site under
1598 19a-755b, as amended by this act, and (D) designating an unclassified
1599 individual from the office to perform the duties of a health information
1600 technology officer as set forth in sections 17b-59f, as amended by this
1601 act, and 17b-59g, as amended by this act;

1602 [(4)] (5) Directing and overseeing the [Office of Health Care Access]
1603 Health Systems Planning Unit established under section 19a-612, as
1604 amended by this act, and all of its duties and responsibilities as set
1605 forth in chapter 368z; and

1606 [(5)] (6) Convening forums and meetings with state government and

1607 external stakeholders, including, but not limited to, the Connecticut
1608 Health Insurance Exchange, to discuss health care issues designed to
1609 develop effective health care cost and quality strategies.

1610 (c) The Office of Health Strategy shall constitute a successor, in
1611 accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the
1612 functions, powers and duties of the following:

1613 (1) The Connecticut Health Insurance Exchange, established
1614 pursuant to section 38a-1081, relating to the administration of the all-
1615 payer claims database pursuant to section 19a-755a, as amended by
1616 this act; and

1617 (2) The Office of the Lieutenant Governor, relating to the (A)
1618 development of a chronic disease plan pursuant to section 19a-6q, as
1619 amended by this act, (B) housing, chairing and staffing of the Health
1620 Care Cabinet pursuant to section 19a-725, as amended by this act, and
1621 (C) (i) appointment of the health information technology officer,
1622 [pursuant to section 19a-755,] and (ii) oversight of the duties of such
1623 health information technology officer as set forth in sections [17b-59,
1624 17b-59a and] 17b-59f, as amended by this act, and 17b-59g, as amended
1625 by this act.

1626 (d) Any order or regulation of the entities listed in subdivisions (1)
1627 and (2) of subsection (c) of this section that is in force on July 1, 2018,
1628 shall continue in force and effect as an order or regulation until
1629 amended, repealed or superseded pursuant to law.

1630 Sec. 56. Section 4-5 of the 2018 supplement to the general statutes is
1631 repealed and the following is substituted in lieu thereof (*Effective July*
1632 *1, 2018*):

1633 As used in sections 4-6, 4-7 and 4-8, the term "department head"
1634 means Secretary of the Office of Policy and Management,
1635 Commissioner of Administrative Services, Commissioner of Revenue
1636 Services, Banking Commissioner, Commissioner of Children and
1637 Families, Commissioner of Consumer Protection, Commissioner of

1638 Correction, Commissioner of Economic and Community Development,
1639 State Board of Education, Commissioner of Emergency Services and
1640 Public Protection, Commissioner of Energy and Environmental
1641 Protection, Commissioner of Agriculture, Commissioner of Public
1642 Health, Insurance Commissioner, Labor Commissioner, Commissioner
1643 of Mental Health and Addiction Services, Commissioner of Social
1644 Services, Commissioner of Developmental Services, Commissioner of
1645 Motor Vehicles, Commissioner of Transportation, Commissioner of
1646 Veterans Affairs, Commissioner of Housing, Commissioner of
1647 Rehabilitation Services, the Commissioner of Early Childhood, [and]
1648 the executive director of the Office of Military Affairs and the
1649 executive director of the Office of Health Strategy. As used in sections
1650 4-6 and 4-7, "department head" also means the Commissioner of
1651 Education.

1652 Sec. 57. Section 4-5 of the 2018 supplement to the general statutes, as
1653 amended by section 6 of public act 17-237 and section 279 of public act
1654 17-2 of the June special session, is repealed and the following is
1655 substituted in lieu thereof (*Effective July 1, 2019*):

1656 As used in sections 4-6, 4-7 and 4-8, the term "department head"
1657 means Secretary of the Office of Policy and Management,
1658 Commissioner of Administrative Services, Commissioner of Revenue
1659 Services, Banking Commissioner, Commissioner of Children and
1660 Families, Commissioner of Consumer Protection, Commissioner of
1661 Correction, Commissioner of Economic and Community Development,
1662 State Board of Education, Commissioner of Emergency Services and
1663 Public Protection, Commissioner of Energy and Environmental
1664 Protection, Commissioner of Agriculture, Commissioner of Public
1665 Health, Insurance Commissioner, Labor Commissioner, Commissioner
1666 of Mental Health and Addiction Services, Commissioner of Social
1667 Services, Commissioner of Developmental Services, Commissioner of
1668 Motor Vehicles, Commissioner of Transportation, Commissioner of
1669 Veterans Affairs, Commissioner of Housing, Commissioner of
1670 Rehabilitation Services, the Commissioner of Early Childhood, the
1671 executive director of the Office of Military Affairs, [and] the executive

1672 director of the Technical Education and Career System and the
1673 executive director of the Office of Health Strategy. As used in sections
1674 4-6 and 4-7, "department head" also means the Commissioner of
1675 Education.

1676 Sec. 58. Section 19a-755a of the 2018 supplement to the general
1677 statutes is repealed and the following is substituted in lieu thereof
1678 (*Effective July 1, 2018*):

1679 (a) As used in this section:

1680 (1) "All-payer claims database" means a database that receives and
1681 stores data from a reporting entity relating to medical insurance
1682 claims, dental insurance claims, pharmacy claims and other insurance
1683 claims information from enrollment and eligibility files.

1684 (2) (A) "Reporting entity" means:

1685 (i) An insurer, as described in section 38a-1, licensed to do health
1686 insurance business in this state;

1687 (ii) A health care center, as defined in section 38a-175;

1688 (iii) An insurer or health care center that provides coverage under
1689 Part C or Part D of Title XVIII of the Social Security Act, as amended
1690 from time to time, to residents of this state;

1691 (iv) A third-party administrator, as defined in section 38a-720;

1692 (v) A pharmacy benefits manager, as defined in section 38a-479aaa;

1693 (vi) A hospital service corporation, as defined in section 38a-199;

1694 (vii) A nonprofit medical service corporation, as defined in section
1695 38a-214;

1696 (viii) A fraternal benefit society, as described in section 38a-595, that
1697 transacts health insurance business in this state;

1698 (ix) A dental plan organization, as defined in section 38a-577;

1699 (x) A preferred provider network, as defined in section 38a-479aa;
1700 and

1701 (xi) Any other person that administers health care claims and
1702 payments pursuant to a contract or agreement or is required by statute
1703 to administer such claims and payments.

1704 (B) "Reporting entity" does not include an employee welfare benefit
1705 plan, as defined in the federal Employee Retirement Income Security
1706 Act of 1974, as amended from time to time, that is also a trust
1707 established pursuant to collective bargaining subject to the federal
1708 Labor Management Relations Act.

1709 (3) "Medicaid data" means the Medicaid provider registry, health
1710 claims data and Medicaid recipient data maintained by the
1711 Department of Social Services.

1712 (b) (1) There is established an all-payer claims database program.
1713 The [Health Information Technology Officer, designated under section
1714 19a-755,] Office of Health Strategy shall: (A) Oversee the planning,
1715 implementation and administration of the all-payer claims database
1716 program for the purpose of collecting, assessing and reporting health
1717 care information relating to safety, quality, cost-effectiveness, access
1718 and efficiency for all levels of health care; (B) ensure that data received
1719 is securely collected, compiled and stored in accordance with state and
1720 federal law; [and] (C) conduct audits of data submitted by reporting
1721 entities in order to verify its accuracy; and (D) in consultation with the
1722 Health Information Technology Advisory Council established under
1723 section 17b-59f, as amended by this act, maintain written procedures
1724 for the administration of such all-payer claims database. Any such
1725 written procedures shall include (i) reporting requirements for
1726 reporting entities, and (ii) requirements for providing notice to a
1727 reporting entity regarding any alleged failure on the part of such
1728 reporting entity to comply with such reporting requirements.

1729 (2) The [Health Information Technology Officer] executive director
1730 of the Office of Health Strategy shall seek funding from the federal

1731 government, other public sources and other private sources to cover
1732 costs associated with the planning, implementation and administration
1733 of the all-payer claims database program.

1734 (3) (A) Upon the adoption of reporting requirements as set forth in
1735 subsection (b) of [section 19a-755] this section, a reporting entity shall
1736 report health care information for inclusion in the all-payer claims
1737 database in a form and manner prescribed by the [Health Information
1738 Technology Officer] executive director of the Office of Health Strategy.
1739 The [Health Information Technology Officer] executive director may,
1740 after notice and hearing, impose a civil penalty on any reporting entity
1741 that fails to report health care information as prescribed. Such civil
1742 penalty shall not exceed one thousand dollars per day for each day of
1743 violation and shall not be imposed as a cost for the purpose of rate
1744 determination or reimbursement by a third-party payer.

1745 (B) The [Health Information Technology Officer] executive director
1746 of the Office of Health Strategy may provide the name of any reporting
1747 entity on which such penalty has been imposed to the Insurance
1748 Commissioner. After consultation with said [officer] executive director,
1749 the commissioner may request the Attorney General to bring an action
1750 in the superior court for the judicial district of Hartford to recover any
1751 penalty imposed pursuant to subparagraph (A) of this subdivision.

1752 (4) The Commissioner of Social Services shall submit Medicaid data
1753 to the [Health Information Technology Officer] executive director of
1754 the Office of Health Strategy for inclusion in the all-payer claims
1755 database only for purposes related to administration of the State
1756 Medicaid Plan, in accordance with 42 CFR 431.301 to 42 CFR 431.306,
1757 inclusive.

1758 (5) The [Health Information Technology Officer] executive director
1759 of the Office of Health Strategy shall: (A) Utilize data in the all-payer
1760 claims database to provide health care consumers in the state with
1761 information concerning the cost and quality of health care services for
1762 the purpose of allowing such consumers to make economically sound
1763 and medically appropriate health care decisions; and (B) make data in

1764 the all-payer claims database available to any state agency, insurer,
1765 employer, health care provider, consumer of health care services or
1766 researcher for the purpose of allowing such person or entity to review
1767 such data as it relates to health care utilization, costs or quality of
1768 health care services. If health information, as defined in 45 CFR
1769 160.103, as amended from time to time, is permitted to be disclosed
1770 under the Health Insurance Portability and Accountability Act of 1996,
1771 P.L. 104-191, as amended from time to time, or regulations adopted
1772 thereunder, any disclosure thereof made pursuant to this subdivision
1773 shall have identifiers removed, as set forth in 45 CFR 164.514, as
1774 amended from time to time. Any disclosure made pursuant to this
1775 subdivision of information other than health information shall be
1776 made in a manner to protect the confidentiality of such other
1777 information as required by state and federal law. The [Health
1778 Information Technology Officer] executive director of the Office of
1779 Health Strategy may set a fee to be charged to each person or entity
1780 requesting access to data stored in the all-payer claims database.

1781 (6) The [Health Information Technology Officer] executive director
1782 of the Office of Health Strategy may (A) in consultation with the All-
1783 Payer Claims Database Advisory Group set forth in section 17b-59f, as
1784 amended by this act, enter into a contract with a person or entity to
1785 plan, implement or administer the all-payer claims database program,
1786 (B) enter into a contract or take any action that is necessary to obtain
1787 data that is the same data required to be submitted by reporting
1788 entities under Medicare Part A or Part B, (C) enter into a contract for
1789 the collection, management or analysis of data received from reporting
1790 entities, and (D) in accordance with subdivision (4) of this subsection,
1791 enter into a contract or take any action that is necessary to obtain
1792 Medicaid data. Any such contract for the collection, management or
1793 analysis of such data shall expressly prohibit the disclosure of such
1794 data for purposes other than the purposes described in this subsection.

1795 (c) Unless otherwise specified, nothing in this section and no action
1796 taken by the executive director of the Office of Health Strategy
1797 pursuant to this section or section 19a-755b, as amended by this act,

1798 shall be construed to preempt, supersede or affect the authority of the
1799 Insurance Commissioner to regulate the business of insurance in the
1800 state.

1801 Sec. 59. Section 19a-755b of the 2018 supplement to the general
1802 statutes is repealed and the following is substituted in lieu thereof
1803 (*Effective July 1, 2018*):

1804 (a) For purposes of this section and sections 19a-904a, 19a-904b and
1805 38a-477d to 38a-477f, inclusive:

1806 (1) "Allowed amount" means the maximum reimbursement dollar
1807 amount that an insured's health insurance policy allows for a specific
1808 procedure or service;

1809 (2) "Consumer health information Internet web site" means an
1810 Internet web site developed and operated by the [Health Information
1811 Technology Officer] Office of Health Strategy to assist consumers in
1812 making informed decisions concerning their health care and informed
1813 choices among health care providers;

1814 (3) "Episode of care" means all health care services related to the
1815 treatment of a condition or a service category for such treatment and,
1816 for acute conditions, includes health care services and treatment
1817 provided from the onset of the condition to its resolution or a service
1818 category for such treatment and, for chronic conditions, includes
1819 health care services and treatment provided over a given period of
1820 time or a service category for such treatment;

1821 (4) "Executive director" means the executive director of the Office of
1822 Health Strategy;

1823 [(4)] (5) "Health care provider" means any individual, corporation,
1824 facility or institution licensed by this state to provide health care
1825 services;

1826 [(5)] (6) "Health carrier" means any insurer, health care center,
1827 hospital service corporation, medical service corporation, fraternal

1828 benefit society or other entity delivering, issuing for delivery,
1829 renewing, amending or continuing any individual or group health
1830 insurance policy in this state providing coverage of the type specified
1831 in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

1832 [(6) "Health Information Technology Officer" means the individual
1833 designated pursuant to section 19a-755;]

1834 (7) "Hospital" has the same meaning as provided in section 19a-490,
1835 as amended by this act;

1836 (8) "Out-of-pocket costs" means costs that are not reimbursed by a
1837 health insurance policy and includes deductibles, coinsurance and
1838 copayments for covered services and other costs to the consumer
1839 associated with a procedure or service;

1840 (9) "Outpatient surgical facility" has the same meaning as provided
1841 in section 19a-493b, as amended by this act; and

1842 (10) "Public or private third party" means the state, the federal
1843 government, employers, a health carrier, third-party administrator, as
1844 defined in section 38a-720, or managed care organization.

1845 (b) (1) Within available resources, the consumer health information
1846 Internet web site shall: (A) Contain information comparing the quality,
1847 price and cost of health care services, including, to the extent
1848 practicable, (i) comparative price and cost information for the health
1849 care services and procedures reported pursuant to subsection (c) of
1850 this section categorized by payer or listed by health care provider, (ii)
1851 links to Internet web sites and consumer tools where consumers may
1852 obtain comparative cost and quality information, including The Joint
1853 Commission and Medicare hospital compare tool, (iii) definitions of
1854 common health insurance and medical terms so consumers may
1855 compare health coverage and understand the terms of their coverage,
1856 and (iv) factors consumers should consider when choosing an
1857 insurance product or provider group, including provider network,
1858 premium, cost sharing, covered services and tier information; (B) be

1859 designed to assist consumers and institutional purchasers in making
1860 informed decisions regarding their health care and informed choices
1861 among health care providers and, to the extent practicable, provide
1862 reference pricing for services paid by various health carriers to health
1863 care providers; (C) present information in language and a format that
1864 is understandable to the average consumer; and (D) be publicized to
1865 the general public. All information outlined in this section shall be
1866 posted on an Internet web site established, or to be established, by the
1867 [Health Information Technology Officer] executive director of the
1868 Office of Health Strategy in a manner and time frame as may be
1869 organizationally and financially reasonable in his or her sole
1870 discretion.

1871 (2) Information collected, stored and published by the [exchange]
1872 Office of Health Strategy pursuant to this section is subject to the
1873 federal Health Insurance Portability and Accountability Act of 1996,
1874 P.L. 104-191, as amended from time to time.

1875 (3) The [Health Information Technology Officer] executive director
1876 of the Office of Health Strategy may consider adding quality measures
1877 to the consumer health information Internet web site. [as
1878 recommended by the State Innovation Model Initiative program
1879 management office.]

1880 (c) Not later than January 1, 2018, and annually thereafter, the
1881 [Health Information Technology Officer] executive director of the
1882 Office of Health Strategy shall, to the extent the information is
1883 available, make available to the public on the consumer health
1884 information Internet web site a list of: (1) The fifty most frequently
1885 occurring inpatient services or procedures in the state; (2) the fifty
1886 most frequently provided outpatient services or procedures in the
1887 state; (3) the twenty-five most frequent surgical services or procedures
1888 in the state; (4) the twenty-five most frequent imaging services or
1889 procedures in the state; and (5) the twenty-five most frequently used
1890 pharmaceutical products and medical devices in the state. Such lists
1891 may (A) be expanded to include additional admissions and

1892 procedures, (B) be based upon those services and procedures that are
1893 most commonly performed by volume or that represent the greatest
1894 percentage of related health care expenditures, or (C) be designed to
1895 include those services and procedures most likely to result in out-of-
1896 pocket costs to consumers or include bundled episodes of care.

1897 (d) Not later than January 1, 2018, and annually thereafter, to the
1898 extent practicable, the [Health Information Technology Officer]
1899 executive director of the Office of Health Strategy shall issue a report,
1900 in a manner to be decided by the [officer] executive director, that
1901 includes the (1) billed and allowed amounts paid to health care
1902 providers in each health carrier's network for each service and
1903 procedure service included pursuant to subsection (c) of this section,
1904 and (2) out-of-pocket costs for each such service and procedure.

1905 (e) (1) On and after January 1, 2018, each hospital shall, at the time
1906 of scheduling a service or procedure for nonemergency care that is
1907 included in the report prepared by the [Health Information
1908 Technology Officer] executive director of the Office of Health Strategy
1909 pursuant to subsection (c) of this section, regardless of the location or
1910 setting where such services are delivered, notify the patient of the
1911 patient's right to make a request for cost and quality information.
1912 Upon the request of a patient for a diagnosis or procedure included in
1913 such report, the hospital shall, not later than three business days after
1914 scheduling such service or procedure, provide written notice,
1915 electronically or by mail, to the patient who is the subject of the service
1916 or procedure concerning: (A) If the patient is uninsured, the amount to
1917 be charged for the service or procedure if all charges are paid in full
1918 without a public or private third party paying any portion of the
1919 charges, including the amount of any facility fee, or, if the hospital is
1920 not able to provide a specific amount due to an inability to predict the
1921 specific treatment or diagnostic code, the estimated maximum allowed
1922 amount or charge for the service or procedure, including the amount
1923 of any facility fee; (B) the corresponding Medicare reimbursement
1924 amount or, if there is no corresponding Medicare reimbursement
1925 amount for such diagnosis or procedure, (i) the approximate amount

1926 Medicare would have paid the hospital for the services on the billing
1927 statement, or (ii) the percentage of the hospital's charges that Medicare
1928 would have paid the hospital for the services; (C) if the patient is
1929 insured, the allowed amount, the toll-free telephone number and the
1930 Internet web site address of the patient's health carrier where the
1931 patient can obtain information concerning charges and out-of-pocket
1932 costs; (D) The Joint Commission's composite accountability rating and
1933 the Medicare hospital compare star rating for the hospital, as
1934 applicable; and (E) the Internet web site addresses for The Joint
1935 Commission and the Medicare hospital compare tool where the patient
1936 may obtain information concerning the hospital.

1937 (2) If the patient is insured and the hospital is out-of-network under
1938 the patient's health insurance policy, such written notice shall include
1939 a statement that the service or procedure will likely be deemed out-of-
1940 network and that any out-of-network applicable rates under such
1941 policy may apply.

1942 Sec. 60. Subsection (a) of section 38a-477e of the 2018 supplement to
1943 the general statutes is repealed and the following is substituted in lieu
1944 thereof (*Effective July 1, 2018*):

1945 (a) On and after January 1, 2017, each health carrier, as defined in
1946 section 19a-755b, as amended by this act, shall maintain an Internet
1947 web site and toll-free telephone number that enables consumers to
1948 request and obtain: (1) Information on in-network costs for inpatient
1949 admissions, health care procedures and services, including (A) the
1950 allowed amount for, at a minimum, admissions and procedures
1951 reported to the [exchange] executive director of the Office of Health
1952 Strategy pursuant to section 19a-755b, as amended by this act, for each
1953 health care provider in the state; (B) the estimated out-of-pocket costs
1954 that a consumer would be responsible for paying for any such
1955 admission or procedure that is medically necessary, including any
1956 facility fee, coinsurance, copayment, deductible or other out-of-pocket
1957 expense; and (C) data or other information concerning (i) quality
1958 measures for the health care provider, (ii) patient satisfaction, to the

1959 extent such information is available, (iii) a directory of participating
1960 providers, as defined in section 38a-472f, in accordance with the
1961 provisions of section 38a-477h; and (2) information on out-of-network
1962 costs for inpatient admissions, health care procedures and services.

1963 Sec. 61. Section 17b-59a of the general statutes is repealed and the
1964 following is substituted in lieu thereof (*Effective July 1, 2018*):

1965 (a) As used in this section:

1966 (1) "Electronic health information system" means an information
1967 processing system, involving both computer hardware and software
1968 that deals with the storage, retrieval, sharing and use of health care
1969 information, data and knowledge for communication and decision
1970 making, and includes: (A) An electronic health record that provides
1971 access in real time to a patient's complete medical record; (B) a
1972 personal health record through which an individual, and anyone
1973 authorized by such individual, can maintain and manage such
1974 individual's health information; (C) computerized order entry
1975 technology that permits a health care provider to order diagnostic and
1976 treatment services, including prescription drugs electronically; (D)
1977 electronic alerts and reminders to health care providers to improve
1978 compliance with best practices, promote regular screenings and other
1979 preventive practices, and facilitate diagnoses and treatments; (E) error
1980 notification procedures that generate a warning if an order is entered
1981 that is likely to lead to a significant adverse outcome for a patient; and
1982 (F) tools to allow for the collection, analysis and reporting of data on
1983 adverse events, near misses, the quality and efficiency of care, patient
1984 satisfaction and other healthcare-related performance measures.

1985 (2) "Interoperability" means the ability of two or more systems or
1986 components to exchange information and to use the information that
1987 has been exchanged and includes: (A) The capacity to physically
1988 connect to a network for the purpose of exchanging data with other
1989 users; and (B) the capacity of a connected user to access, transmit,
1990 receive and exchange usable information with other users.

1991 (3) "Standard electronic format" means a format using open
1992 electronic standards that: (A) Enable health information technology to
1993 be used for the collection of clinically specific data; (B) promote the
1994 interoperability of health care information across health care settings,
1995 including reporting to local, state and federal agencies; and (C)
1996 facilitate clinical decision support.

1997 (b) The Commissioner of Social Services, in consultation with the
1998 [Health Information Technology Officer] executive director of the
1999 Office of Health Strategy, established under section 19a-754a, as
2000 amended by this act, shall (1) develop, throughout the Departments of
2001 Developmental Services, Public Health, Correction, Children and
2002 Families, Veterans Affairs and Mental Health and Addiction Services,
2003 uniform management information, uniform statistical information,
2004 uniform terminology for similar facilities, uniform electronic health
2005 information technology standards and uniform regulations for the
2006 licensing of human services facilities, (2) plan for increased
2007 participation of the private sector in the delivery of human services, (3)
2008 provide direction and coordination to federally funded programs in
2009 the human services agencies and recommend uniform system
2010 improvements and reallocation of physical resources and designation
2011 of a single responsibility across human services agencies lines to
2012 facilitate shared services and eliminate duplication.

2013 (c) The [Health Information Technology Officer, designated in
2014 accordance with section 19a-755,] executive director of the Office of
2015 Health Strategy shall, in consultation with the Commissioner of Social
2016 Services and the Health Information Technology Advisory Council,
2017 established pursuant to section 17b-59f, as amended by this act,
2018 implement and periodically revise the state-wide health information
2019 technology plan established pursuant to this section and shall establish
2020 electronic data standards to facilitate the development of integrated
2021 electronic health information systems for use by health care providers
2022 and institutions that receive state funding. Such electronic data
2023 standards shall: (1) Include provisions relating to security, privacy,
2024 data content, structures and format, vocabulary and transmission

2025 protocols; (2) limit the use and dissemination of an individual's Social
2026 Security number and require the encryption of any Social Security
2027 number provided by an individual; (3) require privacy standards no
2028 less stringent than the "Standards for Privacy of Individually
2029 Identifiable Health Information" established under the Health
2030 Insurance Portability and Accountability Act of 1996, P.L. 104-191, as
2031 amended from time to time, and contained in 45 CFR 160, 164; (4)
2032 require that individually identifiable health information be secure and
2033 that access to such information be traceable by an electronic audit trail;
2034 (5) be compatible with any national data standards in order to allow
2035 for interstate interoperability; (6) permit the collection of health
2036 information in a standard electronic format; and (7) be compatible with
2037 the requirements for an electronic health information system.

2038 (d) The [Health Information Technology Officer] executive director
2039 of the Office of Health Strategy shall, within existing resources and in
2040 consultation with the State Health Information Technology Advisory
2041 Council: (1) Oversee the development and implementation of the State-
2042 wide Health Information Exchange in conformance with section 17b-
2043 59d, as amended by this act; (2) coordinate the state's health
2044 information technology and health information exchange efforts to
2045 ensure consistent and collaborative cross-agency planning and
2046 implementation; and (3) serve as the state liaison to, and work
2047 collaboratively with, the State-wide Health Information Exchange
2048 established pursuant to section 17b-59d, as amended by this act, to
2049 ensure consistency between the state-wide health information
2050 technology plan and the State-wide Health Information Exchange and
2051 to support the state's health information technology and exchange
2052 goals.

2053 (e) The state-wide health information technology plan, implemented
2054 and periodically revised pursuant to subsection (c) of this section, shall
2055 enhance interoperability to support optimal health outcomes and
2056 include, but not be limited to (1) general standards and protocols for
2057 health information exchange, and (2) national data standards to
2058 support secure data exchange data standards to facilitate the

2059 development of a state-wide, integrated electronic health information
2060 system for use by health care providers and institutions that are
2061 licensed by the state. Such electronic data standards shall (A) include
2062 provisions relating to security, privacy, data content, structures and
2063 format, vocabulary and transmission protocols, (B) be compatible with
2064 any national data standards in order to allow for interstate
2065 interoperability, (C) permit the collection of health information in a
2066 standard electronic format, and (D) be compatible with the
2067 requirements for an electronic health information system.

2068 (f) Not later than February 1, 2017, and annually thereafter, the
2069 [Health Information Technology Officer] executive director of the
2070 Office of Health Strategy, in consultation with the State Health
2071 Information Technology Advisory Council, shall report in accordance
2072 with the provisions of section 11-4a to the joint standing committees of
2073 the General Assembly having cognizance of matters relating to human
2074 services and public health concerning: (1) The development and
2075 implementation of the state-wide health information technology plan
2076 and data standards, established and implemented by the [Health
2077 Information Technology Officer] executive director of the Office of
2078 Health Strategy pursuant to this section; (2) the establishment of the
2079 State-wide Health Information Exchange; and (3) recommendations for
2080 policy, regulatory and legislative changes and other initiatives to
2081 promote the state's health information technology and exchange goals.

2082 Sec. 62. Section 17b-59c of the general statutes is repealed and the
2083 following is substituted in lieu thereof (*Effective July 1, 2018*):

2084 (a) Matters of policy related to subsection (b) of section 17b-59a, as
2085 amended by this act, involving more than one of the agencies
2086 designated in [section 17b-59a] said subsection shall be presented to
2087 the Commissioner of Social Services for his or her approval prior to
2088 implementation.

2089 (b) Matters of program development related to subsection (b) of
2090 section 17b-59a, as amended by this act, involving more than one of the
2091 agencies designated in [section 17b-59a] said subsection shall be

2092 presented to the commissioner for his or her approval prior to
2093 implementation.

2094 (c) Any plan of any agency designated in subsection (b) of section
2095 17b-59a, as amended by this act, for the future use or development of
2096 property or other resources for the purposes of said subsection shall be
2097 submitted to the commissioner for his or her approval prior to
2098 implementation.

2099 [(d) Any plan of any agency designated in section 17b-59a for
2100 revision of the health information technology plan shall be submitted
2101 to the commissioner for his or her approval prior to implementation. If
2102 such approval requires funding, after the commissioner has granted
2103 approval, the commissioner shall submit such revisions to the
2104 Secretary of the Office of Policy and Management.

2105 (e) On or before January 1, 2015, and annually thereafter, the
2106 commissioner shall submit, in accordance with the provisions of
2107 section 11-4a, the state-wide health information technology plan, as
2108 revised in accordance with section 17b-59a, to the joint standing
2109 committees of the General Assembly having cognizance of matters
2110 relating to human services, public health and appropriations and the
2111 budgets of state agencies.]

2112 Sec. 63. Subdivision (1) of subsection (d) of section 17b-59d of the
2113 2018 supplement to the general statutes is repealed and the following
2114 is substituted in lieu thereof (*Effective July 1, 2018*):

2115 (d) (1) The [Health Information Technology Officer, designated in
2116 accordance with section 19a-755] executive director of the Office of
2117 Health Strategy, in consultation with the Secretary of the Office of
2118 Policy and Management and the State Health Information Technology
2119 Advisory Council, established pursuant to section 17b-59f, as amended
2120 by this act, shall, upon the approval by the State Bond Commission of
2121 bond funds authorized by the General Assembly for the purposes of
2122 establishing a State-wide Health Information Exchange, develop and
2123 issue a request for proposals for the development, management and

2124 operation of the State-wide Health Information Exchange. Such
2125 request shall promote the reuse of any and all enterprise health
2126 information technology assets, such as the existing Provider Directory,
2127 Enterprise Master Person Index, Direct Secure Messaging Health
2128 Information Service provider infrastructure, analytic capabilities and
2129 tools that exist in the state or are in the process of being deployed. Any
2130 enterprise health information exchange technology assets purchased
2131 after June 2, 2016, and prior to the implementation of the State-wide
2132 Health Information Exchange shall be capable of interoperability with
2133 a State-wide Health Information Exchange.

2134 Sec. 64. Subsection (f) of section 17b-59d of the 2018 supplement to
2135 the general statutes is repealed and the following is substituted in lieu
2136 thereof (*Effective July 1, 2018*):

2137 (f) The [Health Information Technology Officer] executive director
2138 of the Office of Health Strategy shall have administrative authority
2139 over the State-wide Health Information Exchange. The [Health
2140 Information Technology Officer] executive director shall be
2141 responsible for designating, and posting on its Internet web site, the
2142 list of systems, technologies, entities and programs that shall constitute
2143 the State-wide Health Information Exchange. Systems, technologies,
2144 entities, and programs that have not been so designated shall not be
2145 considered part of said exchange.

2146 Sec. 65. Section 17b-59f of the 2018 supplement to the general
2147 statutes is repealed and the following is substituted in lieu thereof
2148 (*Effective July 1, 2018*):

2149 (a) There shall be a State Health Information Technology Advisory
2150 Council to advise the [Health Information Technology Officer]
2151 executive director of the Office of Health Strategy and the health
2152 information technology officer, designated in accordance with section
2153 [19a-755] 19a-754a, as amended by this act, in developing priorities
2154 and policy recommendations for advancing the state's health
2155 information technology and health information exchange efforts and
2156 goals and to advise the [Health Information Technology Officer]

2157 executive director and officer in the development and implementation
2158 of the state-wide health information technology plan and standards
2159 and the State-wide Health Information Exchange, established pursuant
2160 to section 17b-59d, as amended by this act. The advisory council shall
2161 also advise the [Health Information Technology Officer] executive
2162 director and officer regarding the development of appropriate
2163 governance, oversight and accountability measures to ensure success
2164 in achieving the state's health information technology and exchange
2165 goals.

2166 (b) The council shall consist of the following members:

2167 (1) [The Health Information Technology Officer, appointed in
2168 accordance with section 19a-755, or the Health Information
2169 Technology Officer's designee;] One member appointed by the
2170 executive director of the Office of Health Strategy, who shall be an
2171 expert in state health care reform initiatives;

2172 (2) The health information technology officer, designated in
2173 accordance with section 19a-754a, as amended by this act, or the health
2174 information technology officer's designee;

2175 [(2)] (3) The Commissioners of Social Services, Mental Health and
2176 Addiction Services, Children and Families, Correction, Public Health
2177 and Developmental Services, or the commissioners' designees;

2178 [(3)] (4) The Chief Information Officer of the state, or the Chief
2179 Information Officer's designee;

2180 [(4)] (5) The chief executive officer of the Connecticut Health
2181 Insurance Exchange, or the chief executive officer's designee;

2182 [(5) The director of the state innovation model initiative program
2183 management office, or the director's designee;]

2184 (6) The chief information officer of The University of Connecticut
2185 Health Center, or [said] the chief information officer's designee;

2186 (7) The Healthcare Advocate, or the Healthcare Advocate's
2187 designee;

2188 (8) The Comptroller, or the Comptroller's designee;

2189 (9) Five members appointed by the Governor, one each [of whom]
2190 who shall be (A) a representative of a health system that includes more
2191 than one hospital, (B) a representative of the health insurance industry,
2192 (C) an expert in health information technology, (D) a health care
2193 consumer or consumer advocate, and (E) a current or former employee
2194 or trustee of a plan established pursuant to subdivision (5) of
2195 subsection (c) of 29 USC 186;

2196 (10) Three members appointed by the president pro tempore of the
2197 Senate, one each who shall be (A) a representative of a federally
2198 qualified health center, (B) a provider of behavioral health services,
2199 and (C) a [representative of the Connecticut State Medical Society]
2200 physician licensed under chapter 370;

2201 (11) Three members appointed by the speaker of the House of
2202 Representatives, one each who shall be (A) a technology expert who
2203 represents a hospital system, as defined in section 19a-486i, as
2204 amended by this act, (B) a provider of home health care services, and
2205 (C) a health care consumer or a health care consumer advocate;

2206 (12) One member appointed by the majority leader of the Senate,
2207 who shall be a representative of an independent community hospital;

2208 (13) One member appointed by the majority leader of the House of
2209 Representatives, who shall be a physician who provides services in a
2210 multispecialty group and who is not employed by a hospital;

2211 (14) One member appointed by the minority leader of the Senate,
2212 who shall be a primary care physician who provides services in a small
2213 independent practice;

2214 (15) One member appointed by the minority leader of the House of
2215 Representatives, who shall be an expert in health care analytics and

2216 quality analysis;

2217 (16) The president pro tempore of the Senate, or the president's
2218 designee;

2219 (17) The speaker of the House of Representatives, or the speaker's
2220 designee;

2221 (18) The minority leader of the Senate, or the minority leader's
2222 designee; and

2223 (19) The minority leader of the House of Representatives, or the
2224 minority leader's designee.

2225 (c) Any member appointed or designated under subdivisions (10) to
2226 (19), inclusive, of subsection (b) of this section may be a member of the
2227 General Assembly.

2228 (d) (1) The [Health Information Technology Officer, appointed in
2229 accordance with section 19a-755] health information technology officer,
2230 designated in accordance with section 19a-754a, as amended by this
2231 act, shall serve as a chairperson of the council. The council shall elect a
2232 second chairperson from among its members, who shall not be a state
2233 official. The chairpersons of the council may establish subcommittees
2234 and working groups and may appoint individuals other than members
2235 of the council to serve as members of the subcommittees or working
2236 groups. The terms of the members shall be coterminous with the terms
2237 of the appointing authority for each member and subject to the
2238 provisions of section 4-1a. If any vacancy occurs on the council, the
2239 appointing authority having the power to make the appointment
2240 under the provisions of this section shall appoint a person in
2241 accordance with the provisions of this section. A majority of the
2242 members of the council shall constitute a quorum. Members of the
2243 council shall serve without compensation, but shall be reimbursed for
2244 all reasonable expenses incurred in the performance of their duties.

2245 (2) The chairpersons of the council may appoint up to four
2246 additional members to the council, who shall serve at the pleasure of

2247 the chairpersons.

2248 (e) (1) The council shall establish a working group to be known as
2249 the All-Payer Claims Database Advisory Group. Said group shall
2250 include, but need not be limited to, (A) the Secretary of the Office of
2251 Policy and Management, the Comptroller, the Commissioners of
2252 Public Health, Social Services and Mental Health and Addiction
2253 Services, the Insurance Commissioner, the Healthcare Advocate and
2254 the Chief Information Officer, or their designees; (B) a representative of
2255 the Connecticut State Medical Society; and (C) representatives of
2256 health insurance companies, health insurance purchasers, hospitals,
2257 consumer advocates and health care providers. The [Health
2258 Information Technology Officer] health information technology officer
2259 may appoint additional members to said group.

2260 (2) The All-Payer Claims Database Advisory Group shall develop a
2261 plan to implement a state-wide multipayer data initiative to enhance
2262 the state's use of health care data from multiple sources to increase
2263 efficiency, enhance outcomes and improve the understanding of health
2264 care expenditures in the public and private sectors.

2265 (f) Prior to submitting any application, proposal, planning
2266 document or other request seeking federal grants, matching funds or
2267 other federal support for health information technology or health
2268 information exchange, the [Health Information Technology Officer]
2269 executive director of the Office of Health Strategy or the Commissioner
2270 of Social Services shall present such application, proposal, document
2271 or other request to the council for review and comment.

2272 Sec. 66. Section 17b-59g of the 2018 supplement to the general
2273 statutes is repealed and the following is substituted in lieu thereof
2274 (*Effective July 1, 2018*):

2275 (a) The state, acting by and through the Secretary of the Office of
2276 Policy and Management, in collaboration with the [Health Information
2277 Technology Officer designated under section 19a-755, and the
2278 Lieutenant Governor] executive director of the Office of Health

2279 Strategy, shall establish a program to expedite the development of the
2280 State-wide Health Information Exchange, established under section
2281 17b-59d, as amended by this act, to assist the state, health care
2282 providers, insurance carriers, physicians and all stakeholders in
2283 empowering consumers to make effective health care decisions,
2284 promote patient-centered care, improve the quality, safety and value of
2285 health care, reduce waste and duplication of services, support clinical
2286 decision-making, keep confidential health information secure and
2287 make progress toward the state's public health goals. The purposes of
2288 the program shall be to (1) assist the State-wide Health Information
2289 Exchange in establishing and maintaining itself as a neutral and
2290 trusted entity that serves the public good for the benefit of all
2291 Connecticut residents, including, but not limited to, Connecticut health
2292 care consumers and Connecticut health care providers and carriers, (2)
2293 perform, on behalf of the state, the role of intermediary between public
2294 and private stakeholders and customers of the State-wide Health
2295 Information Exchange, and (3) fulfill the responsibilities of the Office
2296 of Health Strategy, as described in section 19a-754a, as amended by
2297 this act.

2298 (b) The [Health Information Technology Officer] executive director
2299 of the Office of Health Strategy, in consultation with the health
2300 information technology officer, designated in accordance with section
2301 19a-754, as amended by this act, shall design, and the Secretary of the
2302 Office of Policy and Management, in collaboration with said [officer]
2303 executive director, may establish or incorporate an entity to implement
2304 the program established under subsection (a) of this section. Such
2305 entity shall, without limitation, be owned and governed, in whole or in
2306 part, by a party or parties other than the state and may be organized as
2307 a nonprofit entity.

2308 (c) Any entity established or incorporated pursuant to subsection (b)
2309 of this section shall have its powers vested in and exercised by a board
2310 of directors. The board of directors shall be comprised of the following
2311 members who shall each serve for a term of two years:

2312 (1) One member who shall have expertise as an advocate for
2313 consumers of health care, appointed by the Governor;

2314 (2) One member who shall have expertise as a clinical medical
2315 doctor, appointed by the president pro tempore of the Senate;

2316 (3) One member who shall have expertise in the area of hospital
2317 administration, appointed by the speaker of the House of
2318 Representatives;

2319 (4) One member who shall have expertise in the area of corporate
2320 law or finance, appointed by the minority leader of the Senate;

2321 (5) One member who shall have expertise in group health insurance
2322 coverage, appointed by the minority leader of the House of
2323 Representatives;

2324 (6) The Chief Information Officer [,] and the Secretary of the Office
2325 of Policy and Management, [and the Health Information Technology
2326 Officer,] or their designees, who shall serve as ex-officio, voting
2327 members of the board; and

2328 (7) The [Health Information Technology Officer, or his or her
2329 designee] health information technology officer, designated in
2330 accordance with section 19a-754a, as amended by this act, who shall
2331 serve as chairperson of the board.

2332 (d) [All initial appointments shall be made not later than February 1,
2333 2018.] Any vacancy shall be filled by the appointing authority for the
2334 balance of the unexpired term. If an appointing authority fails to make
2335 an initial appointment on or before sixty days after the establishment
2336 of such entity, or to fill a vacancy in an appointment on or before sixty
2337 days after the date of such vacancy, the Governor shall make such
2338 appointment or fill such vacancy.

2339 (e) [The] Any entity established or incorporated under subsection
2340 [(c)] (b) of this section may (1) employ a staff and fix their duties,
2341 qualifications and compensation; (2) solicit, receive and accept aid or

2342 contributions, including money, property, labor and other things of
2343 value from any source; (3) receive, and manage on behalf of the state,
2344 funding from the federal government, other public sources or private
2345 sources to cover costs associated with the planning, implementation
2346 and administration of the State-wide Health Information Exchange; (4)
2347 collect and remit fees set by the Health Information Technology Officer
2348 charged to persons or entities for access to or interaction with said
2349 exchange; (5) retain outside consultants and technical experts; (6)
2350 maintain an office in the state at such place or places as such entity
2351 may designate; (7) procure insurance against loss in connection with
2352 such entity's property and other assets in such amounts and from such
2353 insurers as such entity deems desirable; (8) sue and be sued and plead
2354 and be impleaded; (9) borrow money for the purpose of obtaining
2355 working capital; and (10) subject to the powers, purposes and
2356 restrictions of sections 17b-59a, as amended by this act, 17b-59d, as
2357 amended by this act, and 17b-59f, as amended by this act, [and 19a-
2358 755,] do all acts and things necessary and convenient to carry out the
2359 purposes of this section and section 19a-754a, as amended by this act.

2360 Sec. 67. Subsection (b) of section 2-124a of the 2018 supplement to
2361 the general statutes is repealed and the following is substituted in lieu
2362 thereof (*Effective July 1, 2018*):

2363 (b) Appointments to the working group pursuant to subsection (a)
2364 of this section shall include, but need not be limited to, the [Health
2365 Information Technology Officer, designated in accordance with section
2366 19a-755] executive director of the Office of Health Strategy, or such
2367 executive director's designee, and representatives from the insurance
2368 industry, the health care industry, the Connecticut Education Network,
2369 broadband Internet service providers, the Connecticut Technology
2370 Council, the bioscience industry and public or private universities and
2371 research institutions. The working group shall also include the
2372 Consumer Counsel, or the Consumer Counsel's designee. All
2373 appointments to the working group shall be made not later than thirty
2374 days after June 30, 2017. Any member of the working group
2375 established pursuant to this section may be a member of the working

2376 group established pursuant to special act 16-20 or a member of the
2377 General Assembly or the Commission on Economic Competitiveness.

2378 Sec. 68. Section 19a-612 of the general statutes is repealed and the
2379 following is substituted in lieu thereof (*Effective July 1, 2018*):

2380 (a) There is established, within the [Department of Public Health, a
2381 division] Office of Health Strategy, established under section 19a-754a,
2382 as amended by this act, a unit to be known as the [Office of Health
2383 Care Access] Health Systems Planning Unit. The [division] unit, under
2384 the direction of the [Commissioner of Public Health] executive director
2385 of the Office of Health Strategy, shall constitute a successor to the
2386 former Office of Health Care Access, in accordance with the provisions
2387 of sections 4-38d and 4-39.

2388 (b) Any order, decision, agreed settlement [,] or regulation of the
2389 former Office of Health Care Access which is in force on [October 6,
2390 2009] July 1, 2018, shall continue in force and effect as an order or
2391 regulation of the [Department of Public Health] Office of Health
2392 Strategy until amended, repealed or superseded pursuant to law.

2393 (c) If the words "Office of Health Care Access" are used or referred
2394 to in any public or special act of 2009 or in any section of the general
2395 statutes which is amended in 2009, such words shall be deemed to
2396 mean or refer to the Office of Health Care Access division within the
2397 Department of Public Health. If the words "Office of Health Care
2398 Access" are used or referred to in any public or special act of 2018 or in
2399 any section of the general statutes which is amended in 2018, such
2400 words shall be deemed to mean or refer to the Health Systems
2401 Planning Unit within the Office of Health Strategy.

2402 Sec. 69. Section 19a-612d of the general statutes is repealed and the
2403 following is substituted in lieu thereof (*Effective July 1, 2018*):

2404 (a) [Notwithstanding any provision of the general statutes, there
2405 shall be a Deputy Commissioner of Public Health who] The executive
2406 director of the Office of Health Strategy shall oversee the [Office of

2407 Health Care Access division of the Department of Public Health]
2408 Health Systems Planning Unit and [who] shall exercise independent
2409 decision-making authority over all certificate of need decisions.

2410 (b) Notwithstanding the provisions of subsection (a) of this section,
2411 the Deputy Commissioner of Public Health shall retain independent
2412 decision-making authority over only the certificate of need
2413 applications that are pending before the Office of Health Care Access
2414 and have been deemed completed by said office on or before July 1,
2415 2018. Following the issuance by the deputy commissioner of a final
2416 decision on any such certificate of need application, the executive
2417 director of the Office of Health Strategy shall exercise independent
2418 authority on any further action required on a certificate of need issued
2419 pursuant to such application.

2420 Sec. 70. Section 19a-613 of the general statutes is repealed and the
2421 following is substituted in lieu thereof (*Effective July 1, 2018*):

2422 (a) The [Office of Health Care Access] Health Systems Planning Unit
2423 may employ the most effective and practical means necessary to fulfill
2424 the purposes of this chapter, which may include, but need not be
2425 limited to:

2426 (1) Collecting patient-level outpatient data from health care facilities
2427 or institutions, as defined in section 19a-630, as amended by this act;

2428 (2) Establishing a cooperative data collection effort, across public
2429 and private sectors, to assure that adequate health care personnel
2430 demographics are readily available; and

2431 (3) Performing the duties and functions as enumerated in subsection
2432 (b) of this section.

2433 (b) The [office] unit shall: (1) Authorize and oversee the collection of
2434 data required to carry out the provisions of this chapter; (2) oversee
2435 and coordinate health system planning for the state; (3) monitor health
2436 care costs; and (4) implement and oversee health care reform as
2437 enacted by the General Assembly.

2438 (c) The [Commissioner of Public Health] executive director of the
2439 Office of Health Strategy, or any person the [commissioner] executive
2440 director designates, may conduct a hearing and render a final decision
2441 in any case when a hearing is required or authorized under the
2442 provisions of any statute dealing with the [Office of Health Care
2443 Access] Health Systems Planning Unit.

2444 Sec. 71. Section 19a-614 of the general statutes is repealed and the
2445 following is substituted in lieu thereof (*Effective July 1, 2018*):

2446 [(a)] The [Commissioner of Public Health] executive director of the
2447 Office of Health Strategy may employ and pay professional and
2448 support staff subject to the provisions of chapter 67 and contract with
2449 and engage consultants and other independent professionals as may
2450 be necessary or desirable to carry out the functions of the [office]
2451 Health Systems Planning Unit.

2452 [(b)] The commissioner may establish a consumer education unit
2453 within the office to provide information to residents of the state
2454 concerning the availability of public and private health care coverage.]

2455 Sec. 72. Section 19a-630 of the general statutes is repealed and the
2456 following is substituted in lieu thereof (*Effective July 1, 2018*):

2457 As used in this chapter, unless the context otherwise requires:

2458 (1) "Affiliate" means a person, entity or organization controlling,
2459 controlled by or under common control with another person, entity or
2460 organization. Affiliate does not include a medical foundation
2461 organized under chapter 594b.

2462 (2) "Applicant" means any person or health care facility that applies
2463 for a certificate of need pursuant to section 19a-639a, as amended by
2464 this act.

2465 (3) "Bed capacity" means the total number of inpatient beds in a
2466 facility licensed by the Department of Public Health under sections
2467 19a-490 to 19a-503, inclusive, as amended by this act.

2468 (4) "Capital expenditure" means an expenditure that under
2469 generally accepted accounting principles consistently applied is not
2470 properly chargeable as an expense of operation or maintenance and
2471 includes acquisition by purchase, transfer, lease or comparable
2472 arrangement, or through donation, if the expenditure would have been
2473 considered a capital expenditure had the acquisition been by purchase.

2474 (5) "Certificate of need" means a certificate issued by the [office]
2475 unit.

2476 (6) "Days" means calendar days.

2477 [(7) "Deputy commissioner" means the deputy commissioner of
2478 Public Health who oversees the Office of Health Care Access division
2479 of the Department of Public Health.

2480 (8) "Commissioner" means the Commissioner of Public Health.]

2481 (7) "Executive director" means the executive director of the Office of
2482 Health Strategy.

2483 [(9)] (8) "Free clinic" means a private, nonprofit community-based
2484 organization that provides medical, dental, pharmaceutical or mental
2485 health services at reduced cost or no cost to low-income, uninsured
2486 and underinsured individuals.

2487 [(10)] (9) "Large group practice" means eight or more full-time
2488 equivalent physicians, legally organized in a partnership, professional
2489 corporation, limited liability company formed to render professional
2490 services, medical foundation, not-for-profit corporation, faculty
2491 practice plan or other similar entity (A) in which each physician who is
2492 a member of the group provides substantially the full range of services
2493 that the physician routinely provides, including, but not limited to,
2494 medical care, consultation, diagnosis or treatment, through the joint
2495 use of shared office space, facilities, equipment or personnel; (B) for
2496 which substantially all of the services of the physicians who are
2497 members of the group are provided through the group and are billed
2498 in the name of the group practice and amounts so received are treated

2499 as receipts of the group; or (C) in which the overhead expenses of, and
2500 the income from, the group are distributed in accordance with
2501 methods previously determined by members of the group. An entity
2502 that otherwise meets the definition of group practice under this section
2503 shall be considered a group practice although its shareholders,
2504 partners or owners of the group practice include single-physician
2505 professional corporations, limited liability companies formed to render
2506 professional services or other entities in which beneficial owners are
2507 individual physicians.

2508 [(11)] (10) "Health care facility" means (A) hospitals licensed by the
2509 Department of Public Health under chapter 368v; (B) specialty
2510 hospitals; (C) freestanding emergency departments; (D) outpatient
2511 surgical facilities, as defined in section 19a-493b, as amended by this
2512 act, and licensed under chapter 368v; (E) a hospital or other facility or
2513 institution operated by the state that provides services that are eligible
2514 for reimbursement under Title XVIII or XIX of the federal Social
2515 Security Act, 42 USC 301, as amended; (F) a central service facility; (G)
2516 mental health facilities; (H) substance abuse treatment facilities; and (I)
2517 any other facility requiring certificate of need review pursuant to
2518 subsection (a) of section 19a-638, as amended by this act. "Health care
2519 facility" includes any parent company, subsidiary, affiliate or joint
2520 venture, or any combination thereof, of any such facility.

2521 [(12)] (11) "Nonhospital based" means located at a site other than the
2522 main campus of the hospital.

2523 [(13)] (12) "Office" means the Office of Health [Care Access division
2524 within the Department of Public Health] Strategy.

2525 [(14)] (13) "Person" means any individual, partnership, corporation,
2526 limited liability company, association, governmental subdivision,
2527 agency or public or private organization of any character, but does not
2528 include the agency conducting the proceeding.

2529 [(15)] (14) "Physician" has the same meaning as provided in section
2530 20-13a.

2531 [(16)] (15) "Transfer of ownership" means a transfer that impacts or
2532 changes the governance or controlling body of a health care facility,
2533 institution or large group practice, including, but not limited to, all
2534 affiliations, mergers or any sale or transfer of net assets of a health care
2535 facility.

2536 (16) "Unit" means the Health Systems Planning Unit.

2537 Sec. 73. Subsection (b) of section 19a-631 of the general statutes is
2538 repealed and the following is substituted in lieu thereof (*Effective July*
2539 *1, 2018*):

2540 (b) Each hospital shall annually pay to the [Commissioner of Public
2541 Health] executive director of the Office of Health Strategy, for deposit
2542 in the General Fund, an amount equal to its share of the actual
2543 expenditures made by the [office] unit during each fiscal year
2544 including the cost of fringe benefits for [office] unit personnel as
2545 estimated by the Comptroller, the amount of expenses for central state
2546 services attributable to the [office] unit for the fiscal year as estimated
2547 by the Comptroller, plus the expenditures made on behalf of the
2548 [office] unit from the Capital Equipment Purchase Fund pursuant to
2549 section 4a-9 for such year. Payments shall be made by assessment of all
2550 hospitals of the costs calculated and collected in accordance with the
2551 provisions of this section and section 19a-632, as amended by this act.
2552 If for any reason a hospital ceases operation, any unpaid assessment
2553 for the operations of the [office] unit shall be reapportioned among the
2554 remaining hospitals to be paid in addition to any other assessment.

2555 Sec. 74. Section 19a-632 of the general statutes is repealed and the
2556 following is substituted in lieu thereof (*Effective July 1, 2018*):

2557 (a) On or before September first, annually, the [Office of Health Care
2558 Access] Health Systems Planning Unit shall determine (1) the total net
2559 revenue of each hospital for the most recently completed hospital fiscal
2560 year beginning October first; and (2) the proposed assessment on the
2561 hospital for the state fiscal year. The assessment on each hospital shall
2562 be calculated by multiplying the hospital's percentage share of the total

2563 net revenue specified in subdivision (1) of this subsection times the
2564 costs of the [office] unit, as determined in subsection (b) of this section.

2565 (b) The costs of the [office] unit shall be the total of (1) the amount
2566 appropriated for expenses for the operation of the [office] unit for the
2567 fiscal year, as estimated by the Comptroller, (2) the cost of fringe
2568 benefits for [office] unit personnel for such year, as estimated by the
2569 Comptroller, (3) the amount of expenses for central state services
2570 attributable to the [office] unit for the fiscal year as estimated by the
2571 Comptroller, and (4) the estimated expenditures on behalf of the
2572 [office] unit from the Capital Equipment Purchase Fund pursuant to
2573 section 4a-9 for such year, provided for purposes of this calculation the
2574 amount of expenses for the operation of the [office] unit for the fiscal
2575 year as estimated by the Comptroller, plus the cost of fringe benefits
2576 for personnel, the amount of expenses for said central state services for
2577 the fiscal year as estimated by the Comptroller, and said estimated
2578 expenditures from the Capital Equipment Purchase Fund pursuant to
2579 section 4a-9 shall be deemed to be the actual expenditures of the
2580 [office] unit.

2581 (c) On or before December thirty-first, annually, for each fiscal year,
2582 each hospital shall pay the [office] unit twenty-five per cent of its
2583 proposed assessment, adjusted to reflect any credit or amount due
2584 under the recalculated assessment for the preceding state fiscal year as
2585 determined pursuant to subsection (d) of this section or any
2586 reapportioned assessment pursuant to subsection (b) of section 19a-
2587 631, as amended by this act. The hospital shall pay the remaining
2588 seventy-five per cent of its assessment to the [office] unit in three equal
2589 installments on or before the following March thirty-first, June thirtieth
2590 and September thirtieth, annually.

2591 (d) Immediately following the close of each state fiscal year the
2592 [commissioner] executive director shall recalculate the proposed
2593 assessment for each hospital based on the costs of the [office] unit in
2594 accordance with subsection (b) of this section using the actual
2595 expenditures made by the [office] unit during that fiscal year and the

2596 actual expenditures made on behalf of the [office] unit from the Capital
2597 Equipment Purchase Fund pursuant to section 4a-9. On or before
2598 August thirty-first, annually, the [office] unit shall render to each
2599 hospital a statement showing the difference between the respective
2600 recalculated assessment and the amount previously paid. On or before
2601 September thirtieth, the [commissioner] executive director, after
2602 receiving any objections to such statements, shall make such
2603 adjustments which in said [commissioner's] executive director's
2604 opinion may be indicated and shall render an adjusted assessment, if
2605 any, to the affected hospitals. Adjustments to reflect any credit or
2606 amount due under the recalculated assessment for the previous state
2607 fiscal year shall be made to the proposed assessment due on or before
2608 December thirty-first of the following state fiscal year.

2609 (e) If any assessment is not paid when due, the [commissioner]
2610 executive director shall impose a fee equal to (1) two per cent of the
2611 assessment if such failure to pay is for not more than five days, (2) five
2612 per cent of the assessment if such failure to pay is for more than five
2613 days but not more than fifteen days, or (3) ten per cent of the
2614 assessment if such failure to pay is for more than fifteen days. If a
2615 hospital fails to pay any assessment for more than thirty days after the
2616 date when due, the [commissioner] executive director may, in addition
2617 to the fees imposed pursuant to this subsection, impose a civil penalty
2618 of up to one thousand dollars per day for each day past the initial
2619 thirty days that the assessment is not paid. Any civil penalty
2620 authorized by this subsection shall be imposed by the [commissioner]
2621 executive director in accordance with subsections (b) to (e), inclusive,
2622 of section 19a-653, as amended by this act.

2623 (f) The [office] unit shall deposit all payments received pursuant to
2624 this section with the State Treasurer. The moneys so deposited shall be
2625 credited to the General Fund and shall be accounted for as expenses
2626 recovered from hospitals.

2627 Sec. 75. Subsection (b) of section 19a-632a of the general statutes is
2628 repealed and the following is substituted in lieu thereof (*Effective July*

2629 1, 2018):

2630 (b) The [Department of Public Health] Office of Health Strategy may
2631 require a hospital to pay an assessment levied pursuant to section 19a-
2632 632, as amended by this act, by way of an approved method of
2633 electronic funds transfer.

2634 Sec. 76. Subsection (f) of section 19a-632a of the general statutes is
2635 repealed and the following is substituted in lieu thereof (*Effective July*
2636 *1, 2018*):

2637 (f) The [department] office shall deposit all payments received
2638 pursuant to this section with the State Treasurer. The moneys so
2639 deposited shall be credited to the General Fund and shall be accounted
2640 for as expenses recovered from hospitals.

2641 Sec. 77. Section 19a-633 of the general statutes is repealed and the
2642 following is substituted in lieu thereof (*Effective July 1, 2018*):

2643 The [commissioner] executive director, or any agent authorized by
2644 [him] such executive director to conduct any inquiry, investigation or
2645 hearing under the provisions of this chapter, shall have power to
2646 administer oaths and take testimony under oath relative to the matter
2647 of inquiry or investigation. At any hearing ordered by the office, the
2648 [commissioner] executive director or such agent having authority by
2649 law to issue such process may subpoena witnesses and require the
2650 production of records, papers and documents pertinent to such
2651 inquiry. If any person disobeys such process or, having appeared in
2652 obedience thereto, refuses to answer any pertinent question put to
2653 [him] such person by the [commissioner] executive director or [his]
2654 such executive director's authorized agent or to produce any records
2655 and papers pursuant thereto, the [commissioner] executive director or
2656 [his] such executive director's agent may apply to the superior court
2657 for the judicial district of Hartford or for the judicial district wherein
2658 the person resides or wherein the business has been conducted, or to
2659 any judge of said court if the same is not in session, setting forth such
2660 disobedience to process or refusal to answer, and said court or such

2661 judge shall cite such person to appear before said court or such judge
2662 to answer such question or to produce such records and papers.

2663 Sec. 78. Section 19a-634 of the general statutes is repealed and the
2664 following is substituted in lieu thereof (*Effective July 1, 2018*):

2665 (a) The [Office of Health Care Access] Health Systems Planning Unit
2666 shall conduct, on a biennial basis, a state-wide health care facility
2667 utilization study. Such study may include an assessment of: (1)
2668 Current availability and utilization of acute hospital care, hospital
2669 emergency care, specialty hospital care, outpatient surgical care,
2670 primary care and clinic care; (2) geographic areas and subpopulations
2671 that may be underserved or have reduced access to specific types of
2672 health care services; and (3) other factors that the [office] unit deems
2673 pertinent to health care facility utilization. Not later than June thirtieth
2674 of the year in which the biennial study is conducted, the
2675 [Commissioner of Public Health] executive director of the Office of
2676 Health Strategy shall report, in accordance with section 11-4a, to the
2677 Governor and the joint standing committees of the General Assembly
2678 having cognizance of matters relating to public health and human
2679 services on the findings of the study. Such report may also include the
2680 [office's] unit's recommendations for addressing identified gaps in the
2681 provision of health care services and recommendations concerning a
2682 lack of access to health care services.

2683 (b) The [office] unit, in consultation with such other state agencies as
2684 the [Commissioner of Public Health] executive director deems
2685 appropriate, shall establish and maintain a state-wide health care
2686 facilities and services plan. Such plan may include, but not be limited
2687 to: (1) An assessment of the availability of acute hospital care, hospital
2688 emergency care, specialty hospital care, outpatient surgical care,
2689 primary care and clinic care; (2) an evaluation of the unmet needs of
2690 persons at risk and vulnerable populations as determined by the
2691 [commissioner] executive director; (3) a projection of future demand
2692 for health care services and the impact that technology may have on
2693 the demand, capacity or need for such services; and (4)

2694 recommendations for the expansion, reduction or modification of
2695 health care facilities or services. In the development of the plan, the
2696 [office] unit shall consider the recommendations of any advisory
2697 bodies which may be established by the [commissioner] executive
2698 director. The [commissioner] executive director may also incorporate
2699 the recommendations of authoritative organizations whose mission is
2700 to promote policies based on best practices or evidence-based research.
2701 The [commissioner] executive director, in consultation with hospital
2702 representatives, shall develop a process that encourages hospitals to
2703 incorporate the state-wide health care facilities and services plan into
2704 hospital long-range planning and shall facilitate communication
2705 between appropriate state agencies concerning innovations or changes
2706 that may affect future health planning. The [office] unit shall update
2707 the state-wide health care facilities and services plan not less than once
2708 every two years.

2709 (c) For purposes of conducting the state-wide health care facility
2710 utilization study and preparing the state-wide health care facilities and
2711 services plan, the [office] unit shall establish and maintain an
2712 inventory of all health care facilities, the equipment identified in
2713 subdivisions (9) and (10) of subsection (a) of section 19a-638, as
2714 amended by this act, and services in the state, including health care
2715 facilities that are exempt from certificate of need requirements under
2716 subsection (b) of section 19a-638, as amended by this act. The [office]
2717 unit shall develop an inventory questionnaire to obtain the following
2718 information: (1) The name and location of the facility; (2) the type of
2719 facility; (3) the hours of operation; (4) the type of services provided at
2720 that location; and (5) the total number of clients, treatments, patient
2721 visits, procedures performed or scans performed in a calendar year.
2722 The inventory shall be completed biennially by health care facilities
2723 and providers and such health care facilities and providers shall not be
2724 required to provide patient specific or financial data.

2725 Sec. 79. Section 19a-638 of the general statutes is repealed and the
2726 following is substituted in lieu thereof (*Effective July 1, 2018*):

2727 (a) A certificate of need issued by the [office] unit shall be required
2728 for:

2729 (1) The establishment of a new health care facility;

2730 (2) A transfer of ownership of a health care facility;

2731 (3) A transfer of ownership of a large group practice to any entity
2732 other than a (A) physician, or (B) group of two or more physicians,
2733 legally organized in a partnership, professional corporation or limited
2734 liability company formed to render professional services and not
2735 employed by or an affiliate of any hospital, medical foundation,
2736 insurance company or other similar entity;

2737 (4) The establishment of a freestanding emergency department;

2738 (5) The termination of inpatient or outpatient services offered by a
2739 hospital, including, but not limited to, the termination by a short-term
2740 acute care general hospital or children's hospital of inpatient and
2741 outpatient mental health and substance abuse services;

2742 (6) The establishment of an outpatient surgical facility, as defined in
2743 section 19a-493b, as amended by this act, or as established by a short-
2744 term acute care general hospital;

2745 (7) The termination of surgical services by an outpatient surgical
2746 facility, as defined in section 19a-493b, as amended by this act, or a
2747 facility that provides outpatient surgical services as part of the
2748 outpatient surgery department of a short-term acute care general
2749 hospital, provided termination of outpatient surgical services due to
2750 (A) insufficient patient volume, or (B) the termination of any
2751 subspecialty surgical service, shall not require certificate of need
2752 approval;

2753 (8) The termination of an emergency department by a short-term
2754 acute care general hospital;

2755 (9) The establishment of cardiac services, including inpatient and

2756 outpatient cardiac catheterization, interventional cardiology and
2757 cardiovascular surgery;

2758 (10) The acquisition of computed tomography scanners, magnetic
2759 resonance imaging scanners, positron emission tomography scanners
2760 or positron emission tomography-computed tomography scanners, by
2761 any person, physician, provider, short-term acute care general hospital
2762 or children's hospital, except (A) as provided for in subdivision (22) of
2763 subsection (b) of this section, and (B) a certificate of need issued by the
2764 [office] unit shall not be required where such scanner is a replacement
2765 for a scanner that was previously acquired through certificate of need
2766 approval or a certificate of need determination;

2767 (11) The acquisition of nonhospital based linear accelerators;

2768 (12) An increase in the licensed bed capacity of a health care facility;

2769 (13) The acquisition of equipment utilizing technology that has not
2770 previously been utilized in the state;

2771 (14) An increase of two or more operating rooms within any three-
2772 year period, commencing on and after October 1, 2010, by an
2773 outpatient surgical facility, as defined in section 19a-493b, as amended
2774 by this act, or by a short-term acute care general hospital; and

2775 (15) The termination of inpatient or outpatient services offered by a
2776 hospital or other facility or institution operated by the state that
2777 provides services that are eligible for reimbursement under Title XVIII
2778 or XIX of the federal Social Security Act, 42 USC 301, as amended.

2779 (b) A certificate of need shall not be required for:

2780 (1) Health care facilities owned and operated by the federal
2781 government;

2782 (2) The establishment of offices by a licensed private practitioner,
2783 whether for individual or group practice, except when a certificate of
2784 need is required in accordance with the requirements of section 19a-

2785 493b, as amended by this act, or subdivision (3), (10) or (11) of
2786 subsection (a) of this section;

2787 (3) A health care facility operated by a religious group that
2788 exclusively relies upon spiritual means through prayer for healing;

2789 (4) Residential care homes, nursing homes and rest homes, as
2790 defined in subsection (c) of section 19a-490;

2791 (5) An assisted living services agency, as defined in section 19a-490,
2792 as amended by this act;

2793 (6) Home health agencies, as defined in section 19a-490, as amended
2794 by this act;

2795 (7) Hospice services, as described in section 19a-122b;

2796 (8) Outpatient rehabilitation facilities;

2797 (9) Outpatient chronic dialysis services;

2798 (10) Transplant services;

2799 (11) Free clinics, as defined in section 19a-630, as amended by this
2800 act;

2801 (12) School-based health centers and expanded school health sites,
2802 as such terms are defined in section 19a-6r, community health centers,
2803 as defined in section 19a-490a, not-for-profit outpatient clinics licensed
2804 in accordance with the provisions of chapter 368v and federally
2805 qualified health centers;

2806 (13) A program licensed or funded by the Department of Children
2807 and Families, provided such program is not a psychiatric residential
2808 treatment facility;

2809 (14) Any nonprofit facility, institution or provider that has a contract
2810 with, or is certified or licensed to provide a service for, a state agency
2811 or department for a service that would otherwise require a certificate

2812 of need. The provisions of this subdivision shall not apply to a short-
2813 term acute care general hospital or children's hospital, or a hospital or
2814 other facility or institution operated by the state that provides services
2815 that are eligible for reimbursement under Title XVIII or XIX of the
2816 federal Social Security Act, 42 USC 301, as amended;

2817 (15) A health care facility operated by a nonprofit educational
2818 institution exclusively for students, faculty and staff of such institution
2819 and their dependents;

2820 (16) An outpatient clinic or program operated exclusively by or
2821 contracted to be operated exclusively by a municipality, municipal
2822 agency, municipal board of education or a health district, as described
2823 in section 19a-241;

2824 (17) A residential facility for persons with intellectual disability
2825 licensed pursuant to section 17a-227 and certified to participate in the
2826 Title XIX Medicaid program as an intermediate care facility for
2827 individuals with intellectual disabilities;

2828 (18) Replacement of existing imaging equipment if such equipment
2829 was acquired through certificate of need approval or a certificate of
2830 need determination, provided a health care facility, provider,
2831 physician or person notifies the [office] unit of the date on which the
2832 equipment is replaced and the disposition of the replaced equipment;

2833 (19) Acquisition of cone-beam dental imaging equipment that is to
2834 be used exclusively by a dentist licensed pursuant to chapter 379;

2835 (20) The partial or total elimination of services provided by an
2836 outpatient surgical facility, as defined in section 19a-493b, as amended
2837 by this act, except as provided in subdivision (6) of subsection (a) of
2838 this section and section 19a-639e, as amended by this act;

2839 (21) The termination of services for which the Department of Public
2840 Health has requested the facility to relinquish its license; or

2841 (22) Acquisition of any equipment by any person that is to be used

2842 exclusively for scientific research that is not conducted on humans.

2843 (c) (1) Any person, health care facility or institution that is unsure
2844 whether a certificate of need is required under this section, or (2) any
2845 health care facility that proposes to relocate pursuant to section 19a-
2846 639c, as amended by this act, shall send a letter to the [office] unit that
2847 describes the project and requests that the [office] unit make a
2848 determination as to whether a certificate of need is required. In the
2849 case of a relocation of a health care facility, the letter shall include
2850 information described in section 19a-639c, as amended by this act. A
2851 person, health care facility or institution making such request shall
2852 provide the [office] unit with any information the [office] unit requests
2853 as part of its determination process.

2854 (d) The [Commissioner of Public Health] executive director of the
2855 Office of Health Strategy may implement policies and procedures
2856 necessary to administer the provisions of this section while in the
2857 process of adopting such policies and procedures as regulation,
2858 provided the [commissioner] executive director holds a public hearing
2859 prior to implementing the policies and procedures and [prints] posts
2860 notice of intent to adopt regulations [in the Connecticut Law Journal]
2861 on the office's Internet web site and the eRegulations System not later
2862 than twenty days after the date of implementation. Policies and
2863 procedures implemented pursuant to this section shall be valid until
2864 the time final regulations are adopted. [Final regulations shall be
2865 adopted by December 31, 2011.]

2866 Sec. 80. Section 19a-639 of the general statutes is repealed and the
2867 following is substituted in lieu thereof (*Effective July 1, 2018*):

2868 (a) In any deliberations involving a certificate of need application
2869 filed pursuant to section 19a-638, as amended by this act, the [office]
2870 unit shall take into consideration and make written findings
2871 concerning each of the following guidelines and principles:

2872 (1) Whether the proposed project is consistent with any applicable
2873 policies and standards adopted in regulations by the [Department of

2874 Public Health] Office of Health Strategy;

2875 (2) The relationship of the proposed project to the state-wide health
2876 care facilities and services plan;

2877 (3) Whether there is a clear public need for the health care facility or
2878 services proposed by the applicant;

2879 (4) Whether the applicant has satisfactorily demonstrated how the
2880 proposal will impact the financial strength of the health care system in
2881 the state or that the proposal is financially feasible for the applicant;

2882 (5) Whether the applicant has satisfactorily demonstrated how the
2883 proposal will improve quality, accessibility and cost effectiveness of
2884 health care delivery in the region, including, but not limited to,
2885 provision of or any change in the access to services for Medicaid
2886 recipients and indigent persons;

2887 (6) The applicant's past and proposed provision of health care
2888 services to relevant patient populations and payer mix, including, but
2889 not limited to, access to services by Medicaid recipients and indigent
2890 persons;

2891 (7) Whether the applicant has satisfactorily identified the population
2892 to be served by the proposed project and satisfactorily demonstrated
2893 that the identified population has a need for the proposed services;

2894 (8) The utilization of existing health care facilities and health care
2895 services in the service area of the applicant;

2896 (9) Whether the applicant has satisfactorily demonstrated that the
2897 proposed project shall not result in an unnecessary duplication of
2898 existing or approved health care services or facilities;

2899 (10) Whether an applicant, who has failed to provide or reduced
2900 access to services by Medicaid recipients or indigent persons, has
2901 demonstrated good cause for doing so, which shall not be
2902 demonstrated solely on the basis of differences in reimbursement rates

2903 between Medicaid and other health care payers;

2904 (11) Whether the applicant has satisfactorily demonstrated that the
2905 proposal will not negatively impact the diversity of health care
2906 providers and patient choice in the geographic region; and

2907 (12) Whether the applicant has satisfactorily demonstrated that any
2908 consolidation resulting from the proposal will not adversely affect
2909 health care costs or accessibility to care.

2910 (b) In deliberations as described in subsection (a) of this section,
2911 there shall be a presumption in favor of approving the certificate of
2912 need application for a transfer of ownership of a large group practice,
2913 as described in subdivision (3) of subsection (a) of section 19a-638, as
2914 amended by this act, when an offer was made in response to a request
2915 for proposal or similar voluntary offer for sale.

2916 (c) The [office] unit, as it deems necessary, may revise or
2917 supplement the guidelines and principles, [through regulation
2918 prescribed in subsection (a) of this section] set forth in subsection (a) of
2919 this section, through regulation.

2920 (d) (1) For purposes of this subsection and subsection (e) of this
2921 section:

2922 (A) "Affected community" means a municipality where a hospital is
2923 physically located or a municipality whose inhabitants are regularly
2924 served by a hospital;

2925 (B) "Hospital" has the same meaning as provided in section 19a-490,
2926 as amended by this act;

2927 (C) "New hospital" means a hospital as it exists after the approval of
2928 an agreement pursuant to section 19a-486b, as amended by this act, or
2929 a certificate of need application for a transfer of ownership of a
2930 hospital;

2931 (D) "Purchaser" means a person who is acquiring, or has acquired,

2932 any assets of a hospital through a transfer of ownership of a hospital;

2933 (E) "Transacting party" means a purchaser and any person who is a
2934 party to a proposed agreement for transfer of ownership of a hospital;

2935 (F) "Transfer" means to sell, transfer, lease, exchange, option,
2936 convey, give or otherwise dispose of or transfer control over,
2937 including, but not limited to, transfer by way of merger or joint
2938 venture not in the ordinary course of business; and

2939 (G) "Transfer of ownership of a hospital" means a transfer that
2940 impacts or changes the governance or controlling body of a hospital,
2941 including, but not limited to, all affiliations, mergers or any sale or
2942 transfer of net assets of a hospital and for which a certificate of need
2943 application or a certificate of need determination letter is filed on or
2944 after December 1, 2015.

2945 (2) In any deliberations involving a certificate of need application
2946 filed pursuant to section 19a-638, as amended by this act, that involves
2947 the transfer of ownership of a hospital, the [office] unit shall, in
2948 addition to the guidelines and principles set forth in subsection (a) of
2949 this section and those prescribed through regulation pursuant to
2950 subsection (c) of this section, take into consideration and make written
2951 findings concerning each of the following guidelines and principles:

2952 (A) Whether the applicant fairly considered alternative proposals or
2953 offers in light of the purpose of maintaining health care provider
2954 diversity and consumer choice in the health care market and access to
2955 affordable quality health care for the affected community; and

2956 (B) Whether the plan submitted pursuant to section 19a-639a, as
2957 amended by this act, demonstrates, in a manner consistent with this
2958 chapter, how health care services will be provided by the new hospital
2959 for the first three years following the transfer of ownership of the
2960 hospital, including any consolidation, reduction, elimination or
2961 expansion of existing services or introduction of new services.

2962 (3) The [office] unit shall deny any certificate of need application

2963 involving a transfer of ownership of a hospital unless the
2964 [commissioner] executive director finds that the affected community
2965 will be assured of continued access to high quality and affordable
2966 health care after accounting for any proposed change impacting
2967 hospital staffing.

2968 (4) The [office] unit may deny any certificate of need application
2969 involving a transfer of ownership of a hospital subject to a cost and
2970 market impact review pursuant to section 19a-639f, as amended by this
2971 act, if the [commissioner] executive director finds that (A) the affected
2972 community will not be assured of continued access to high quality and
2973 affordable health care after accounting for any consolidation in the
2974 hospital and health care market that may lessen health care provider
2975 diversity, consumer choice and access to care, and (B) any likely
2976 increases in the prices for health care services or total health care
2977 spending in the state may negatively impact the affordability of care.

2978 (5) The [office] unit may place any conditions on the approval of a
2979 certificate of need application involving a transfer of ownership of a
2980 hospital consistent with the provisions of this chapter. Before placing
2981 any such conditions, the [office] unit shall weigh the value of such
2982 conditions in promoting the purposes of this chapter against the
2983 individual and cumulative burden of such conditions on the
2984 transacting parties and the new hospital. For each condition imposed,
2985 the [office] unit shall include a concise statement of the legal and
2986 factual basis for such condition and the provision or provisions of this
2987 chapter that it is intended to promote. Each condition shall be
2988 reasonably tailored in time and scope. The transacting parties or the
2989 new hospital shall have the right to make a request to the [office] unit
2990 for an amendment to, or relief from, any condition based on changed
2991 circumstances, hardship or for other good cause.

2992 (e) (1) If the certificate of need application (A) involves the transfer
2993 of ownership of a hospital, (B) the purchaser is a hospital, as defined in
2994 section 19a-490, as amended by this act, whether located within or
2995 outside the state, that had net patient revenue for fiscal year 2013 in an

2996 amount greater than one billion five hundred million dollars or a
2997 hospital system, as defined in section 19a-486i, as amended by this act,
2998 whether located within or outside the state, that had net patient
2999 revenue for fiscal year 2013 in an amount greater than one billion five
3000 hundred million dollars, or any person that is organized or operated
3001 for profit, and (C) such application is approved, the [office] unit shall
3002 hire an independent consultant to serve as a post-transfer compliance
3003 reporter for a period of three years after completion of the transfer of
3004 ownership of the hospital. Such reporter shall, at a minimum: (i) Meet
3005 with representatives of the purchaser, the new hospital and members
3006 of the affected community served by the new hospital not less than
3007 quarterly; and (ii) report to the [office] unit not less than quarterly
3008 concerning (I) efforts the purchaser and representatives of the new
3009 hospital have taken to comply with any conditions the [office] unit
3010 placed on the approval of the certificate of need application and plans
3011 for future compliance, and (II) community benefits and
3012 uncompensated care provided by the new hospital. The purchaser
3013 shall give the reporter access to its records and facilities for the
3014 purposes of carrying out the reporter's duties. The purchaser shall hold
3015 a public hearing in the municipality in which the new hospital is
3016 located not less than annually during the reporting period to provide
3017 for public review and comment on the reporter's reports and findings.

3018 (2) If the reporter finds that the purchaser has breached a condition
3019 of the approval of the certificate of need application, the [office] unit
3020 may, in consultation with the purchaser, the reporter and any other
3021 interested parties it deems appropriate, implement a performance
3022 improvement plan designed to remedy the conditions identified by the
3023 reporter and continue the reporting period for up to one year
3024 following a determination by the [office] unit that such conditions
3025 have been resolved.

3026 (3) The purchaser shall provide funds, in an amount determined by
3027 the [office] unit not to exceed two hundred thousand dollars annually,
3028 for the hiring of the post-transfer compliance reporter.

3029 (f) Nothing in subsection (d) or (e) of this section shall apply to a
3030 transfer of ownership of a hospital in which either a certificate of need
3031 application is filed on or before December 1, 2015, or where a
3032 certificate of need determination letter is filed on or before December 1,
3033 2015.

3034 Sec. 81. Section 19a-639a of the general statutes is repealed and the
3035 following is substituted in lieu thereof (*Effective July 1, 2018*):

3036 (a) An application for a certificate of need shall be filed with the
3037 [office] unit in accordance with the provisions of this section and any
3038 regulations adopted by the [Department of Public Health] Office of
3039 Health Strategy. The application shall address the guidelines and
3040 principles set forth in (1) subsection (a) of section 19a-639, as amended
3041 by this act, and (2) regulations adopted by the department. The
3042 applicant shall include with the application a nonrefundable
3043 application fee of five hundred dollars.

3044 (b) Prior to the filing of a certificate of need application, the
3045 applicant shall publish notice that an application is to be submitted to
3046 the [office] unit in a newspaper having a substantial circulation in the
3047 area where the project is to be located. Such notice shall (1) be
3048 published (A) not later than twenty days prior to the date of filing of
3049 the certificate of need application, and (B) for not less than three
3050 consecutive days, and (2) contain a brief description of the nature of
3051 the project and the street address where the project is to be located. An
3052 applicant shall file the certificate of need application with the [office]
3053 unit not later than ninety days after publishing notice of the
3054 application in accordance with the provisions of this subsection. The
3055 [office] unit shall not accept the applicant's certificate of need
3056 application for filing unless the application is accompanied by the
3057 application fee prescribed in subsection (a) of this section and proof of
3058 compliance with the publication requirements prescribed in this
3059 subsection.

3060 (c) (1) Not later than five business days after receipt of a properly
3061 filed certificate of need application, the [office] unit shall publish notice

3062 of the application on its Internet web site. Not later than thirty days
3063 after the date of filing of the application, the office may request such
3064 additional information as the [office] unit determines necessary to
3065 complete the application. In addition to any information requested by
3066 the [office] unit, if the application involves the transfer of ownership of
3067 a hospital, as defined in section 19a-639, as amended by this act, the
3068 applicant shall submit to the [office] unit (A) a plan demonstrating
3069 how health care services will be provided by the new hospital for the
3070 first three years following the transfer of ownership of the hospital,
3071 including any consolidation, reduction, elimination or expansion of
3072 existing services or introduction of new services, and (B) the names of
3073 persons currently holding a position with the hospital to be purchased
3074 or the purchaser, as defined in section 19a-639, as amended by this act,
3075 as an officer, director, board member or senior manager, whether or
3076 not such person is expected to hold a position with the hospital after
3077 completion of the transfer of ownership of the hospital and any salary,
3078 severance, stock offering or any financial gain, current or deferred,
3079 such person is expected to receive as a result of, or in relation to, the
3080 transfer of ownership of the hospital.

3081 (2) The applicant shall, not later than sixty days after the date of the
3082 [office's] unit's request, submit any requested information and any
3083 information required under this subsection to the [office] unit. If an
3084 applicant fails to submit such information to the [office] unit within the
3085 sixty-day period, the [office] unit shall consider the application to have
3086 been withdrawn.

3087 (d) Upon determining that an application is complete, the [office]
3088 unit shall provide notice of this determination to the applicant and to
3089 the public in accordance with regulations adopted by the department.
3090 In addition, the [office] unit shall post such notice on its Internet web
3091 site. The date on which the [office] unit posts such notice on its Internet
3092 web site shall begin the review period. Except as provided in this
3093 subsection, (1) the review period for a completed application shall be
3094 ninety days from the date on which the [office] unit posts such notice
3095 on its Internet web site; and (2) the [office] unit shall issue a decision

3096 on a completed application prior to the expiration of the ninety-day
3097 review period. The review period for a completed application that
3098 involves a transfer of a large group practice, as described in
3099 subdivision (3) of subsection (a) of section 19a-638, as amended by this
3100 act, when the offer was made in response to a request for proposal or
3101 similar voluntary offer for sale, shall be sixty days from the date on
3102 which the [office] unit posts notice on its Internet web site. Upon
3103 request or for good cause shown, the [office] unit may extend the
3104 review period for a period of time not to exceed sixty days. If the
3105 review period is extended, the [office] unit shall issue a decision on the
3106 completed application prior to the expiration of the extended review
3107 period. If the [office] unit holds a public hearing concerning a
3108 completed application in accordance with subsection (e) or (f) of this
3109 section, the [office] unit shall issue a decision on the completed
3110 application not later than sixty days after the date the [office] unit
3111 closes the public hearing record.

3112 (e) Except as provided in this subsection, the [office] unit shall hold
3113 a public hearing on a properly filed and completed certificate of need
3114 application if three or more individuals or an individual representing
3115 an entity with five or more people submits a request, in writing, that a
3116 public hearing be held on the application. For a properly filed and
3117 completed certificate of need application involving a transfer of
3118 ownership of a large group practice, as described in subdivision (3) of
3119 subsection (a) of section 19a-638, as amended by this act, when an offer
3120 was made in response to a request for proposal or similar voluntary
3121 offer for sale, a public hearing shall be held if twenty-five or more
3122 individuals or an individual representing twenty-five or more people
3123 submits a request, in writing, that a public hearing be held on the
3124 application. Any request for a public hearing shall be made to the
3125 [office] unit not later than thirty days after the date the [office] unit
3126 determines the application to be complete.

3127 (f) (1) The [office] unit shall hold a public hearing with respect to
3128 each certificate of need application filed pursuant to section 19a-638, as
3129 amended by this act, after December 1, 2015, that concerns any transfer

3130 of ownership involving a hospital. Such hearing shall be held in the
3131 municipality in which the hospital that is the subject of the application
3132 is located.

3133 (2) The [office] unit may hold a public hearing with respect to any
3134 certificate of need application submitted under this chapter. The
3135 [office] unit shall provide not less than two weeks' advance notice to
3136 the applicant, in writing, and to the public by publication in a
3137 newspaper having a substantial circulation in the area served by the
3138 health care facility or provider. In conducting its activities under this
3139 chapter, the [office] unit may hold hearing on applications of a similar
3140 nature at the same time.

3141 (g) The [Commissioner of Public Health] executive director of the
3142 Office of Health Strategy may implement policies and procedures
3143 necessary to administer the provisions of this section while in the
3144 process of adopting such policies and procedures as regulation,
3145 provided the [commissioner] executive director holds a public hearing
3146 prior to implementing the policies and procedures and [prints] posts
3147 notice of intent to adopt regulations on the [department's] office's
3148 Internet web site and the eRegulations System not later than twenty
3149 days after the date of implementation. Policies and procedures
3150 implemented pursuant to this section shall be valid until the time final
3151 regulations are adopted.

3152 Sec. 82. Section 19a-639b of the general statutes is repealed and the
3153 following is substituted in lieu thereof (*Effective July 1, 2018*):

3154 (a) A certificate of need shall be valid only for the project described
3155 in the application. A certificate of need shall be valid for two years
3156 from the date of issuance by the [office] unit. During the period of time
3157 that such certificate is valid and the thirty-day period following the
3158 expiration of the certificate, the holder of the certificate shall provide
3159 the [office] unit with such information as the [office] unit may request
3160 on the development of the project covered by the certificate.

3161 (b) Upon request from a certificate holder, the [office] unit may

3162 extend the duration of a certificate of need for such additional period
3163 of time as the [office] unit determines is reasonably necessary to
3164 expeditiously complete the project. Not later than five business days
3165 after receiving a request to extend the duration of a certificate of need,
3166 the [office] unit shall post such request on its web site. Any person
3167 who wishes to comment on extending the duration of the certificate of
3168 need shall provide written comments to the [office] unit on the
3169 requested extension not later than thirty days after the date the [office]
3170 unit posts notice of the request for an extension of time on its web site.
3171 The [office] unit shall hold a public hearing on any request to extend
3172 the duration of a certificate of need if three or more individuals or an
3173 individual representing an entity with five or more people submits a
3174 request, in writing, that a public hearing be held on the request to
3175 extend the duration of a certificate of need.

3176 (c) In the event that the [office] unit determines that: (1)
3177 Commencement, construction or other preparation has not been
3178 substantially undertaken during a valid certificate of need period; or
3179 (2) the certificate holder has not made a good-faith effort to complete
3180 the project as approved, the [office] unit may withdraw, revoke or
3181 rescind the certificate of need.

3182 (d) A certificate of need shall not be transferable or assignable nor
3183 shall a project be transferred from a certificate holder to another
3184 person.

3185 (e) The [Commissioner of Public Health] executive director of the
3186 Office of Health Strategy may implement policies and procedures
3187 necessary to administer the provisions of this section while in the
3188 process of adopting such policies and procedures as regulation,
3189 provided the [commissioner] executive director holds a public hearing
3190 prior to implementing the policies and procedures and [prints] posts
3191 notice of intent to adopt regulations [in the Connecticut Law Journal]
3192 on the office's Internet web site and the eRegulations System not later
3193 than twenty days after the date of implementation. Policies and
3194 procedures implemented pursuant to this section shall be valid until

3195 the time final regulations are adopted. Final regulations shall be
3196 adopted by December 31, 2011.

3197 Sec. 83. Section 19a-639c of the general statutes is repealed and the
3198 following is substituted in lieu thereof (*Effective July 1, 2018*):

3199 (a) Any health care facility that proposes to relocate a facility shall
3200 submit a letter to the [office] unit, as described in subsection (c) of
3201 section 19a-638, as amended by this act. In addition to the
3202 requirements prescribed in said subsection (c), in such letter the health
3203 care facility shall demonstrate to the satisfaction of the [office] unit that
3204 the population served by the health care facility and the payer mix will
3205 not substantially change as a result of the facility's proposed relocation.
3206 If the facility is unable to demonstrate to the satisfaction of the [office]
3207 unit that the population served and the payer mix will not
3208 substantially change as a result of the proposed relocation, the health
3209 care facility shall apply for certificate of need approval pursuant to
3210 subdivision (1) of subsection (a) of section 19a-638, as amended by this
3211 act, in order to effectuate the proposed relocation.

3212 (b) The [Commissioner of Public Health] executive director of the
3213 Office of Health Strategy may implement policies and procedures
3214 necessary to administer the provisions of this section while in the
3215 process of adopting such policies and procedures as regulation,
3216 provided the [commissioner] executive director holds a public hearing
3217 prior to implementing the policies and procedures and [prints] posts
3218 notice of intent to adopt regulations [in the Connecticut Law Journal]
3219 on the office's Internet web site and the eRegulations System not later
3220 than twenty days after the date of implementation. Policies and
3221 procedures implemented pursuant to this section shall be valid until
3222 the time final regulations are adopted. [Final regulations shall be
3223 adopted by December 31, 2011.]

3224 Sec. 84. Section 19a-639e of the general statutes is repealed and the
3225 following is substituted in lieu thereof (*Effective July 1, 2018*):

3226 (a) Unless otherwise required to file a certificate of need application

3227 pursuant to the provisions of subsection (a) of section 19a-638, as
3228 amended by this act, any health care facility that proposes to terminate
3229 a service that was authorized pursuant to a certificate of need issued
3230 under this chapter shall file a modification request with the [office]
3231 unit not later than sixty days prior to the proposed date of the
3232 termination of the service. The [office] unit may request additional
3233 information from the health care facility as necessary to process the
3234 modification request. In addition, the [office] unit shall hold a public
3235 hearing on any request from a health care facility to terminate a service
3236 pursuant to this section if three or more individuals or an individual
3237 representing an entity with five or more people submits a request, in
3238 writing, that a public hearing be held on the health care facility's
3239 proposal to terminate a service.

3240 (b) Unless otherwise required to file a certificate of need application
3241 pursuant to the provisions of subsection (a) of section 19a-638, as
3242 amended by this act, any health care facility that proposes to terminate
3243 all services offered by such facility, that were authorized pursuant to
3244 one or more certificates of need issued under this chapter, shall
3245 provide notification to the [office] unit not later than sixty days prior to
3246 the termination of services and such facility shall surrender its
3247 certificate of need not later than thirty days prior to the termination of
3248 services.

3249 (c) Unless otherwise required to file a certificate of need application
3250 pursuant to the provisions of subsection (a) of section 19a-638, as
3251 amended by this act, any health care facility that proposes to terminate
3252 the operation of a facility or service for which a certificate of need was
3253 not obtained shall notify the [office] unit not later than sixty days prior
3254 to terminating the operation of the facility or service.

3255 (d) The [Commissioner of Public Health] executive director of the
3256 Office of Health Strategy may implement policies and procedures
3257 necessary to administer the provisions of this section while in the
3258 process of adopting such policies and procedures as regulation,
3259 provided the [commissioner] executive director holds a public hearing

3260 prior to implementing the policies and procedures and [prints] posts
3261 notice of intent to adopt regulations [in the Connecticut Law Journal]
3262 on the office's Internet web site and the eRegulations System not later
3263 than twenty days after the date of implementation. Policies and
3264 procedures implemented pursuant to this section shall be valid until
3265 the time final regulations are adopted. Final regulations shall be
3266 adopted by December 31, 2015.

3267 Sec. 85. Section 19a-639f of the general statutes is repealed and the
3268 following is substituted in lieu thereof (*Effective July 1, 2018*):

3269 (a) The [Office of Healthcare Access division within the Department
3270 of Public Health] Health Systems Planning Unit of the Office of Health
3271 Strategy shall conduct a cost and market impact review in each case
3272 where (1) an application for a certificate of need filed pursuant to
3273 section 19a-638, as amended by this act, involves the transfer of
3274 ownership of a hospital, as defined in section 19a-639, as amended by
3275 this act, and (2) the purchaser is a hospital, as defined in section 19a-
3276 490, as amended by this act, whether located within or outside the
3277 state, that had net patient revenue for fiscal year 2013 in an amount
3278 greater than one billion five hundred million dollars, or a hospital
3279 system, as defined in section 19a-486i, as amended by this act, whether
3280 located within or outside the state, that had net patient revenue for
3281 fiscal year 2013 in an amount greater than one billion five hundred
3282 million dollars or any person that is organized or operated for profit.

3283 (b) Not later than twenty-one days after receipt of a properly filed
3284 certificate of need application involving the transfer of ownership of a
3285 hospital filed on or after December 1, 2015, as described in subsection
3286 (a) of this section, the [office] unit shall initiate such cost and market
3287 impact review by sending the transacting parties a written notice that
3288 shall contain a description of the basis for the cost and market impact
3289 review as well as a request for information and documents. Not later
3290 than thirty days after receipt of such notice, the transacting parties
3291 shall submit to the [office] unit a written response. Such response shall
3292 include, but need not be limited to, any information or documents

3293 requested by the [office] unit concerning the transfer of ownership of
3294 the hospital. The [office] unit shall have the powers with respect to the
3295 cost and market impact review as provided in section 19a-633, as
3296 amended by this act.

3297 (c) The [office] unit shall keep confidential all nonpublic information
3298 and documents obtained pursuant to this section and shall not disclose
3299 the information or documents to any person without the consent of the
3300 person that produced the information or documents, except in a
3301 preliminary report or final report issued in accordance with this
3302 section if the [office] unit believes that such disclosure should be made
3303 in the public interest after taking into account any privacy, trade secret
3304 or anti-competitive considerations. Such information and documents
3305 shall not be deemed a public record, under section 1-210, as amended
3306 by this act, and shall be exempt from disclosure.

3307 (d) The cost and market impact review conducted pursuant to this
3308 section shall examine factors relating to the businesses and relative
3309 market positions of the transacting parties as defined in subsection (d)
3310 of section 19a-639, as amended by this act, and may include, but need
3311 not be limited to: (1) The transacting parties' size and market share
3312 within its primary service area, by major service category and within
3313 its dispersed service areas; (2) the transacting parties' prices for
3314 services, including the transacting parties' relative prices compared to
3315 other health care providers for the same services in the same market;
3316 (3) the transacting parties' health status adjusted total medical expense,
3317 including the transacting parties' health status adjusted total medical
3318 expense compared to that of similar health care providers; (4) the
3319 quality of the services provided by the transacting parties, including
3320 patient experience; (5) the transacting parties' cost and cost trends in
3321 comparison to total health care expenditures state wide; (6) the
3322 availability and accessibility of services similar to those provided by
3323 each transacting party, or proposed to be provided as a result of the
3324 transfer of ownership of a hospital within each transacting party's
3325 primary service areas and dispersed service areas; (7) the impact of the
3326 proposed transfer of ownership of the hospital on competing options

3327 for the delivery of health care services within each transacting party's
3328 primary service area and dispersed service area including the impact
3329 on existing service providers; (8) the methods used by the transacting
3330 parties to attract patient volume and to recruit or acquire health care
3331 professionals or facilities; (9) the role of each transacting party in
3332 serving at-risk, underserved and government payer patient
3333 populations, including those with behavioral, substance use disorder
3334 and mental health conditions, within each transacting party's primary
3335 service area and dispersed service area; (10) the role of each transacting
3336 party in providing low margin or negative margin services within each
3337 transacting party's primary service area and dispersed service area;
3338 (11) consumer concerns, including, but not limited to, complaints or
3339 other allegations that a transacting party has engaged in any unfair
3340 method of competition or any unfair or deceptive act or practice; and
3341 (12) any other factors that the [office] unit determines to be in the
3342 public interest.

3343 (e) Not later than ninety days after the [office] unit determines that
3344 there is substantial compliance with any request for documents or
3345 information issued by the [office] unit in accordance with this section,
3346 or a later date set by mutual agreement of the [office] unit and the
3347 transacting parties, the [office] unit shall make factual findings and
3348 issue a preliminary report on the cost and market impact review. Such
3349 preliminary report shall include, but shall not be limited to, an
3350 indication as to whether a transacting party meets the following
3351 criteria: (1) Currently has or, following the proposed transfer of
3352 operations of the hospital, is likely to have a dominant market share
3353 for the services the transacting party provides; and (2) (A) currently
3354 charges or, following the proposed transfer of operations of the
3355 hospital, is likely to charge prices for services that are materially higher
3356 than the median prices charged by all other health care providers for
3357 the same services in the same market, or (B) currently has or, following
3358 the proposed transfer of operations of a hospital, is likely to have a
3359 health status adjusted total medical expense that is materially higher
3360 than the median total medical expense for all other health care
3361 providers for the same service in the same market.

3362 (f) The transacting parties that are the subject of the cost and market
3363 impact review may respond in writing to the findings in the
3364 preliminary report issued in accordance with subsection (e) of this
3365 section not later than thirty days after the issuance of the preliminary
3366 report. Not later than sixty days after the issuance of the preliminary
3367 report, the [office] unit shall issue a final report of the cost and market
3368 impact review. The [office] unit shall refer to the Attorney General any
3369 final report on any proposed transfer of ownership that meets the
3370 criteria described in subsection (e) of this section.

3371 (g) Nothing in this section shall prohibit a transfer of ownership of a
3372 hospital, provided any such proposed transfer shall not be completed
3373 (1) less than thirty days after the [office] unit has issued a final report
3374 on a cost and market impact review, if such review is required, or (2)
3375 while any action brought by the Attorney General pursuant to
3376 subsection (h) of this section is pending and before a final judgment on
3377 such action is issued by a court of competent jurisdiction.

3378 (h) After the [office] unit refers a final report on a transfer of
3379 ownership of a hospital to the Attorney General under subsection (f) of
3380 this section, the Attorney General may: (1) Conduct an investigation to
3381 determine whether the transacting parties engaged, or, as a result of
3382 completing the transfer of ownership of the hospital, are expected to
3383 engage in unfair methods of competition, anti-competitive behavior or
3384 other conduct in violation of chapter 624 or 735a or any other state or
3385 federal law; and (2) if appropriate, take action under chapter 624 or
3386 735a or any other state law to protect consumers in the health care
3387 market. The [office's] unit's final report may be evidence in any such
3388 action.

3389 (i) For the purposes of this section, the provisions of chapter 735a
3390 may be directly enforced by the Attorney General. Nothing in this
3391 section shall be construed to modify, impair or supersede the
3392 operation of any state antitrust law or otherwise limit the authority of
3393 the Attorney General to (1) take any action against a transacting party
3394 as authorized by any law, or (2) protect consumers in the health care

3395 market under any law. Notwithstanding subdivision (1) of subsection
3396 (a) of section 42-110c, the transacting parties shall be subject to chapter
3397 735a.

3398 (j) The [office] unit shall retain an independent consultant with
3399 expertise on the economic analysis of the health care market and health
3400 care costs and prices to conduct each cost and market impact review,
3401 as described in this section. The [office] unit shall submit bills for such
3402 services to the purchaser, as defined in subsection (d) of section 19a-
3403 639, as amended by this act. Such purchaser shall pay such bills not
3404 later than thirty days after receipt. Such bills shall not exceed two
3405 hundred thousand dollars per application. The provisions of chapter
3406 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply
3407 to any agreement executed pursuant to this subsection.

3408 (k) Any employee of the [office] unit who directly oversees or assists
3409 in conducting a cost and market impact review shall not take part in
3410 factual deliberations or the issuance of a preliminary or final decision
3411 on the certificate of need application concerning the transfer of
3412 ownership of a hospital that is the subject of such cost and market
3413 impact review.

3414 (l) The [Commissioner of Public Health] executive director of the
3415 Office of Health Strategy shall adopt regulations, in accordance with
3416 the provisions of chapter 54, concerning cost and market impact
3417 reviews and to administer the provisions of this section. Such
3418 regulations shall include definitions of the following terms: "Dispersed
3419 service area", "health status adjusted total medical expense", "major
3420 service category", "relative prices", "total health care spending" and
3421 "health care services". The [commissioner] executive director may
3422 implement policies and procedures necessary to administer the
3423 provisions of this section while in the process of adopting such policies
3424 and procedures in regulation form, provided the [commissioner]
3425 executive director publishes notice of intention to adopt the
3426 regulations on the [Department of Public Health's] office's Internet
3427 web site and the eRegulations System not later than twenty days after

3428 implementing such policies and procedures. Policies and procedures
3429 implemented pursuant to this subsection shall be valid until the time
3430 such regulations are effective.

3431 Sec. 86. Section 19a-641 of the general statutes is repealed and the
3432 following is substituted in lieu thereof (*Effective July 1, 2018*):

3433 Any health care facility or institution and any state health care
3434 facility or institution aggrieved by any final decision of said [office]
3435 unit under the provisions of sections 19a-630 to 19a-639e, inclusive, as
3436 amended by this act, may appeal from such decision in accordance
3437 with the provisions of section 4-183, except venue shall be in the
3438 judicial district in which it is located. Such appeal shall have
3439 precedence in respect to order of trial over all other cases except writs
3440 of habeas corpus, actions brought by or on behalf of the state,
3441 including [informations] information on the relation of private
3442 individuals, and appeals from awards or decisions of workers'
3443 compensation commissioners.

3444 Sec. 87. Section 19a-642 of the general statutes is repealed and the
3445 following is substituted in lieu thereof (*Effective July 1, 2018*):

3446 The Superior Court on application of the [office] unit or the
3447 Attorney General, may enforce, by appropriate decree or process, any
3448 provision of this chapter or any act or any order of the [office] unit
3449 rendered in pursuance of any statutory provision.

3450 Sec. 88. Section 19a-643 of the general statutes is repealed and the
3451 following is substituted in lieu thereof (*Effective July 1, 2018*):

3452 (a) The [Department of Public Health] Office of Health Strategy
3453 shall adopt regulations, in accordance with the provisions of chapter
3454 54, to carry out the provisions of sections 19a-630 to 19a-639e,
3455 inclusive, as amended by this act, and sections 19a-644 and 19a-645, as
3456 amended by this act, concerning the submission of data by health care
3457 facilities and institutions, including data on dealings between health
3458 care facilities and institutions and their affiliates, and, with regard to

3459 requests or proposals pursuant to sections 19a-638 to 19a-639e,
3460 inclusive, as amended by this act, by state health care facilities and
3461 institutions, the ongoing inspections by the [office] unit of operating
3462 budgets that have been approved by the health care facilities and
3463 institutions, standard reporting forms and standard accounting
3464 procedures to be utilized by health care facilities and institutions and
3465 the transferability of line items in the approved operating budgets of
3466 the health care facilities and institutions, except that any health care
3467 facility or institution may transfer any amounts among items in its
3468 operating budget. All such transfers shall be reported to the [office
3469 within] unit not later than thirty days [of] after the transfer or transfers.

3470 (b) The [Department of Public Health] Office of Health Strategy may
3471 adopt such regulations, in accordance with the provisions of chapter
3472 54, as are necessary to implement this chapter.

3473 Sec. 89. Section 19a-644 of the general statutes is repealed and the
3474 following is substituted in lieu thereof (*Effective July 1, 2018*):

3475 (a) On or before February twenty-eighth annually, for the fiscal year
3476 ending on September thirtieth of the immediately preceding year, each
3477 short-term acute care general or children's hospital shall report to the
3478 [office] unit with respect to its operations in such fiscal year, in such
3479 form as the [office] unit may by regulation require. Such report shall
3480 include: (1) Salaries and fringe benefits for the ten highest paid
3481 hospital and health system employees; (2) the name of each joint
3482 venture, partnership, subsidiary and corporation related to the
3483 hospital; and (3) the salaries paid to hospital and health system
3484 employees by each such joint venture, partnership, subsidiary and
3485 related corporation and by the hospital to the employees of related
3486 corporations. For purposes of this subsection, "health system" has the
3487 same meaning as provided in section 33-182aa.

3488 (b) The [Department of Public Health] Office of Health Strategy
3489 shall adopt regulations in accordance with chapter 54 to provide for
3490 the collection of data and information in addition to the annual report
3491 required in subsection (a) of this section. Such regulations shall

3492 provide for the submission of information about the operations of the
3493 following entities: Persons or parent corporations that own or control
3494 the health care facility, institution or provider; corporations, including
3495 limited liability corporations, in which the health care facility,
3496 institution, provider, its parent, any type of affiliate or any
3497 combination thereof, owns more than an aggregate of fifty per cent of
3498 the stock or, in the case of nonstock corporations, is the sole member;
3499 and any partnerships in which the person, health care facility,
3500 institution, provider, its parent or an affiliate or any combination
3501 thereof, or any combination of health care providers or related persons,
3502 owns a greater than fifty per cent interest. For purposes of this
3503 [section] subsection, "affiliate" means any person that directly or
3504 indirectly through one or more intermediaries, controls or is controlled
3505 by or is under common control with any health care facility,
3506 institution, provider or person that is regulated in any way under this
3507 chapter. A person is deemed controlled by another person if the other
3508 person, or one of that other person's affiliates, officers, agents or
3509 management employees, acts as a general partner or manager of the
3510 person in question.

3511 (c) Each nonprofit short-term acute care general or children's
3512 hospital shall include in the annual report required pursuant to
3513 subsection (a) of this section a report of all transfers of assets, transfers
3514 of operations or changes of control involving its clinical or nonclinical
3515 services or functions from such hospital to a person or entity organized
3516 or operated for profit.

3517 (d) Each hospital that is a party to a transfer of ownership involving
3518 a hospital for which a certificate of need application was filed and
3519 approved pursuant to this chapter shall, during the fiscal year ending
3520 on September thirtieth of the immediately preceding year, include in
3521 the annual report required pursuant to subsection (a) of this section
3522 any salary, severance payment, stock offering or other financial gain
3523 realized by each officer, director, board member or senior manager of
3524 the hospital as a result of such transaction.

3525 (e) The [office] unit shall require each hospital licensed by the
3526 Department of Public Health, that is not subject to the provisions of
3527 subsection (a) of this section, to report to said [office] unit on its
3528 operations in the preceding fiscal year by filing copies of the hospital's
3529 audited financial statements, except a health system, as defined in
3530 section 19a-508c, as amended by this act, may submit to the [office]
3531 unit one such report that includes the audited financial statements for
3532 each of its hospitals. Such report shall be due at the [office] unit on or
3533 before the close of business on the last business day of the fifth month
3534 following the month in which a hospital's fiscal year ends.

3535 Sec. 90. Section 19a-645 of the general statutes is repealed and the
3536 following is substituted in lieu thereof (*Effective July 1, 2018*):

3537 A nonprofit hospital, licensed by the Department of Public Health,
3538 which provides lodging, care and treatment to members of the public,
3539 and which wishes to enlarge its public facilities by adding contiguous
3540 land and buildings thereon, if any, the title to which it cannot
3541 otherwise acquire, may prefer a complaint for the right to take such
3542 land to the superior court for the judicial district in which such land is
3543 located, provided such hospital shall have received the approval of the
3544 [Office of Health Care Access division] Health Systems Planning Unit
3545 of the [Department of Public Health] Office of Health Strategy in
3546 accordance with the provisions of this chapter. Said court shall appoint
3547 a committee of three disinterested persons, who, after examining the
3548 premises and hearing the parties, shall report to the court as to the
3549 necessity and propriety of such enlargement and as to the quantity,
3550 boundaries and value of the land and buildings thereon, if any, which
3551 they deem proper to be taken for such purpose and the damages
3552 resulting from such taking. If such committee reports that such
3553 enlargement is necessary and proper and the court accepts such report,
3554 the decision of said court thereon shall have the effect of a judgment
3555 and execution may be issued thereon accordingly, in favor of the
3556 person to whom damages may be assessed, for the amount thereof;
3557 and, on payment thereof, the title to the land and buildings thereon, if
3558 any, for such purpose shall be vested in the complainant, but such land

3559 and buildings thereon, if any, shall not be taken until such damages
3560 are paid to such owner or deposited with said court, for such owner's
3561 use, within thirty days after such report is accepted. If such application
3562 is denied, the owner of the land shall recover costs of the applicant, to
3563 be taxed by said court, which may issue execution therefor. Land so
3564 taken shall be held by such hospital and used only for the public
3565 purpose stated in its complaint to the superior court. No land
3566 dedicated or otherwise reserved as open space or park land or for
3567 other recreational purposes and no land belonging to any town, city or
3568 borough shall be taken under the provisions of this section.

3569 Sec. 91. Section 19a-646 of the general statutes is repealed and the
3570 following is substituted in lieu thereof (*Effective July 1, 2018*):

3571 (a) As used in this section:

3572 [(1) "Office" means the Office of Health Care Access division of the
3573 Department of Public Health;]

3574 (1) "Unit" means the Health Systems Planning Unit within the Office
3575 of Health Strategy, established under section 19a-612, as amended by
3576 this act;

3577 (2) "Fiscal year" means the hospital fiscal year, as used for purposes
3578 of this chapter, consisting of a twelve-month period commencing on
3579 October first and ending the following September thirtieth;

3580 (3) "Hospital" means any short-term acute care general or children's
3581 hospital licensed by the Department of Public Health, including the
3582 John Dempsey Hospital of The University of Connecticut Health
3583 Center;

3584 (4) "Payer" means any person, legal entity, governmental body or
3585 eligible organization that meets the definition of an eligible
3586 organization under 42 USC Section 1395mm (b) of the Social Security
3587 Act, or any combination thereof, except for Medicare and Medicaid
3588 which is or may become legally responsible, in whole or in part for the
3589 payment of services rendered to or on behalf of a patient by a hospital.

3590 Payer also includes any legal entity whose membership includes one
3591 or more payers and any third-party payer; and

3592 (5) "Prompt payment" means payment made for services to a
3593 hospital by mail or other means on or before the tenth business day
3594 after receipt of the bill by the payer.

3595 (b) No hospital shall provide a discount or different rate or method
3596 of reimbursement from the filed rates or charges to any payer except as
3597 provided in this section.

3598 (c) (1) Any payer may directly negotiate with a hospital for a
3599 different rate or method of reimbursement, or both, provided the
3600 charges and payments for the payer are on file at the hospital business
3601 office in accordance with this subsection. No discount agreement or
3602 agreement for a different rate or method of reimbursement, or both,
3603 shall be effective until a complete written agreement between the
3604 hospital and the payer is on file at the hospital. Each such agreement
3605 shall be available to the [office] unit for inspection or submission to the
3606 [office] unit upon request, for at least three years after the close of the
3607 applicable fiscal year.

3608 (2) The charges and payments for each payer receiving a discount
3609 shall be accumulated by the hospital for each payer and reported as
3610 required by the [office] unit.

3611 (3) A full written copy of each agreement executed pursuant to this
3612 subsection shall be on file in the hospital business office within twenty-
3613 four hours of execution.

3614 (d) A payer may negotiate with a hospital to obtain a discount on
3615 rates or charges for prompt payment.

3616 (e) A payer may also negotiate for and may receive a discount for
3617 the provision of the following administrative services: (1) A system
3618 which permits the hospital to bill the payer through either a computer-
3619 processed or machine-readable or similar billing procedure; (2) a
3620 system which enables the hospital to verify coverage of a patient by

3621 the payer at the time the service is provided; and (3) a guarantee of
3622 payment within the scope of the agreement between the patient and
3623 the third-party payer for service to the patient prior to the provision of
3624 that service.

3625 (f) No hospital may require a payer to negotiate for another element
3626 or any combination of the above elements of a discount, as established
3627 in subsections (d) and (e) of this section, in order to negotiate for or
3628 obtain a discount for any single element. No hospital may require a
3629 payer to negotiate a discount for all patients covered by such payer in
3630 order to negotiate a discount for any patient or group of patients
3631 covered by such payer.

3632 (g) Any hospital which agrees to provide a discount to a payer
3633 under subsection (d) or (e) of this section shall file a copy of the
3634 agreement in the hospital's business office and shall provide the same
3635 discount to any other payer who agrees to make prompt payment or
3636 provide administrative services similar to that contained in the
3637 agreement. Each agreement filed shall specify on its face that it was
3638 executed and filed pursuant to this subsection.

3639 (h) (1) Nothing in this section shall be construed to require payment
3640 by any payer or purchaser, under any program or contract for
3641 payment or reimbursement of expenses for health care services, for:
3642 (A) Services not covered under such program or contract; or (B) that
3643 portion of any charge for services furnished by a hospital that exceeds
3644 the amount covered by such program or contract.

3645 (2) Nothing in this section shall be construed to supersede or modify
3646 any provision of such program or contract that requires payment of a
3647 copayment, deductible or enrollment fee or that imposes any similar
3648 requirement.

3649 (i) A hospital which has established a program approved by the
3650 [office] unit with one or more banks for the purpose of reducing the
3651 hospital's bad debt load, may reduce its published charges for that
3652 portion of a patient's bill for services which a payer who is a private

individual is or may become legally responsible for, after all other insurers or third-party payers have been assessed their full charges provided (1) prior to the rendering of such services, the hospital and the individual payer or parent or guardian or custodian have agreed in writing that after receipt of any insurer or third-party payment paid in accordance with the full hospital charges the remaining payment due from the private individual for such reduced charges shall be made in whole or in part from the balance on deposit in a bank account which has been established by or on behalf of such individual patient, and (2) such payment is made from such account. Nothing in this section shall relieve a patient or legally liable person from being responsible for the full amount of any underpayment of the hospital's authorized charges excluding any discount under this section, by a patient's insurer or any other third-party payer for that insurer's or third-party payer's portion of the bill. Any reduction in charges granted to an individual or parent or guardian or custodian under this subsection shall be reported to the [office] unit as a contractual allowance. For purposes of this [section] subsection "private individual" shall include a patient's parent, legal guardian or legal custodian but shall not include an insurer or third-party payer.

Sec. 92. Section 19a-649 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) The [office] unit shall review annually the level of uncompensated care provided by each hospital to the indigent. Each hospital shall file annually with the [office] unit its policies regarding the provision of charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices. A hospital shall file its audited financial statements not later than February twenty-eighth of each year, except a health system, as defined in section 19a-508c, as amended by this act, may file one such statement that includes the audited financial statements for each hospital within the health system. Not later than March thirty-first of each year, the hospital shall file a verification of the hospital's net revenue for the most recently completed fiscal year in a format

3687 prescribed by the [office] unit.

3688 (b) Each hospital shall annually report, along with data submitted
3689 pursuant to subsection (a) of this section, (1) the number of applicants
3690 for charity care and reduced cost services, (2) the number of approved
3691 applicants, and (3) the total and average charges and costs of the
3692 amount of charity care and reduced cost services provided.

3693 (c) Each hospital recognized as a nonprofit organization under
3694 Section 501(c)(3) of the Internal Revenue Code of 1986, or any
3695 subsequent corresponding internal revenue code of the United States,
3696 as amended from time to time, shall, along with data submitted
3697 annually pursuant to subsection (a) of this section, submit to the
3698 [office] unit (1) a complete copy of such hospital's most-recently
3699 completed Internal Revenue Service form 990, including all parts and
3700 schedules; and (2) in the form and manner prescribed by the [office]
3701 unit, data compiled to prepare such hospital's community health needs
3702 assessment, as required pursuant to Section 501(r) of the Internal
3703 Revenue Code of 1986, or any subsequent corresponding internal
3704 revenue code of the United States, as amended from time to time,
3705 provided such copy and data submitted pursuant to this subsection
3706 shall not include: (A) Individual patient information, including, but
3707 not limited to, patient-identifiable information; (B) information that is
3708 not owned or controlled by such hospital; (C) information that such
3709 hospital is contractually required to keep confidential or that is
3710 prohibited from disclosure by a data use agreement; or (D) information
3711 concerning research on human subjects as described in section 45 CFR
3712 46.101 et seq., as amended from time to time.

3713 Sec. 93. Section 19a-653 of the general statutes is repealed and the
3714 following is substituted in lieu thereof (*Effective July 1, 2018*):

3715 (a) Any person or health care facility or institution that is required
3716 to file a certificate of need for any of the activities described in section
3717 19a-638, as amended by this act, and any person or health care facility
3718 or institution that is required to file data or information under any
3719 public or special act or under this chapter or sections 19a-486 to 19a-

3720 486h, inclusive, as amended by this act, or any regulation adopted or
3721 order issued under this chapter or said sections, which wilfully fails to
3722 seek certificate of need approval for any of the activities described in
3723 section 19a-638, as amended by this act, or to so file within prescribed
3724 time periods, shall be subject to a civil penalty of up to one thousand
3725 dollars a day for each day such person or health care facility or
3726 institution conducts any of the described activities without certificate
3727 of need approval as required by section 19a-638, as amended by this
3728 act, or for each day such information is missing, incomplete or
3729 inaccurate. Any civil penalty authorized by this section shall be
3730 imposed by the [Department of Public Health] Office of Health
3731 Strategy in accordance with subsections (b) to (e), inclusive, of this
3732 section.

3733 (b) If the [Department of Public Health] Office of Health Strategy
3734 has reason to believe that a violation has occurred for which a civil
3735 penalty is authorized by subsection (a) of this section or subsection (e)
3736 of section 19a-632, as amended by this act, it shall notify the person or
3737 health care facility or institution by first-class mail or personal service.
3738 The notice shall include: (1) A reference to the sections of the statute or
3739 regulation involved; (2) a short and plain statement of the matters
3740 asserted or charged; (3) a statement of the amount of the civil penalty
3741 or penalties to be imposed; (4) the initial date of the imposition of the
3742 penalty; and (5) a statement of the party's right to a hearing.

3743 (c) The person or health care facility or institution to whom the
3744 notice is addressed shall have fifteen business days from the date of
3745 mailing of the notice to make written application to the [office] unit to
3746 request (1) a hearing to contest the imposition of the penalty, or (2) an
3747 extension of time to file the required data. A failure to make a timely
3748 request for a hearing or an extension of time to file the required data or
3749 a denial of a request for an extension of time shall result in a final order
3750 for the imposition of the penalty. All hearings under this section shall
3751 be conducted pursuant to sections 4-176e to 4-184, inclusive. The
3752 [Department of Public Health] Office of Health Strategy may grant an
3753 extension of time for filing the required data or mitigate or waive the

3754 penalty upon such terms and conditions as, in its discretion, it deems
3755 proper or necessary upon consideration of any extenuating factors or
3756 circumstances.

3757 (d) A final order of the [Department of Public Health] Office of
3758 Health Strategy assessing a civil penalty shall be subject to appeal as
3759 set forth in section 4-183 after a hearing before the [office] unit
3760 pursuant to subsection (c) of this section, except that any such appeal
3761 shall be taken to the superior court for the judicial district of New
3762 Britain. Such final order shall not be subject to appeal under any other
3763 provision of the general statutes. No challenge to any such final order
3764 shall be allowed as to any issue which could have been raised by an
3765 appeal of an earlier order, denial or other final decision by the
3766 [Department of Public Health] office.

3767 (e) If any person or health care facility or institution fails to pay any
3768 civil penalty under this section, after the assessment of such penalty
3769 has become final the amount of such penalty may be deducted from
3770 payments to such person or health care facility or institution from the
3771 Medicaid account.

3772 Sec. 94. Section 19a-654 of the general statutes is repealed and the
3773 following is substituted in lieu thereof (*Effective July 1, 2018*):

3774 (a) As used in this section:

3775 (1) "Patient-identifiable data" means any information that identifies
3776 or may reasonably be used as a basis to identify an individual patient;
3777 and

3778 (2) "De-identified patient data" means any information that meets
3779 the requirements for de-identification of protected health information
3780 as set forth in 45 CFR 164.514.

3781 (b) Each short-term acute care general or children's hospital shall
3782 submit patient-identifiable inpatient discharge data and emergency
3783 department data to the [Office of Health Care Access division] Health
3784 Systems Planning Unit of the [Department of Public Health] Office of

3785 Health Strategy to fulfill the responsibilities of the [office] unit. Such
3786 data shall include data taken from patient medical record abstracts and
3787 bills. The [office] unit shall specify the timing and format of such
3788 submissions. Data submitted pursuant to this section may be
3789 submitted through a contractual arrangement with an intermediary
3790 and such contractual arrangement shall (1) comply with the provisions
3791 of the Health Insurance Portability and Accountability Act of 1996 P.L.
3792 104-191 (HIPAA), and (2) ensure that such submission of data is timely
3793 and accurate. The [office] unit may conduct an audit of the data
3794 submitted through such intermediary in order to verify its accuracy.

3795 (c) An outpatient surgical facility, as defined in section 19a-493b, as
3796 amended by this act, a short-term acute care general or children's
3797 hospital, or a facility that provides outpatient surgical services as part
3798 of the outpatient surgery department of a short-term acute care
3799 hospital shall submit to the [office] unit the data identified in
3800 subsection (c) of section 19a-634, as amended by this act. The [office]
3801 unit shall convene a working group consisting of representatives of
3802 outpatient surgical facilities, hospitals and other individuals necessary
3803 to develop recommendations that address current obstacles to, and
3804 proposed requirements for, patient-identifiable data reporting in the
3805 outpatient setting. On or before February 1, 2012, the working group
3806 shall report, in accordance with the provisions of section 11-4a, on its
3807 findings and recommendations to the joint standing committees of the
3808 General Assembly having cognizance of matters relating to public
3809 health and insurance and real estate. Additional reporting of
3810 outpatient data as the [office] unit deems necessary shall begin not
3811 later than July 1, 2015. On or before July 1, [2012] 2018, and annually
3812 thereafter, the Connecticut Association of Ambulatory Surgery Centers
3813 shall provide a progress report to the [Department of Public Health]
3814 Office of Health Strategy, until such time as all ambulatory surgery
3815 centers are in full compliance with the implementation of systems that
3816 allow for the reporting of outpatient data as required by the
3817 [commissioner] executive director. Until such additional reporting
3818 requirements take effect on July 1, 2015, the department may work
3819 with the Connecticut Association of Ambulatory Surgery Centers and

3820 the Connecticut Hospital Association on specific data reporting
3821 initiatives provided that no penalties shall be assessed under this
3822 chapter or any other provision of law with respect to the failure to
3823 submit such data.

3824 (d) Except as provided in this subsection, patient-identifiable data
3825 received by the [office] unit shall be kept confidential and shall not be
3826 considered public records or files subject to disclosure under the
3827 Freedom of Information Act, as defined in section 1-200. The [office]
3828 unit may release de-identified patient data or aggregate patient data to
3829 the public in a manner consistent with the provisions of 45 CFR
3830 164.514. Any de-identified patient data released by the [office] unit
3831 shall exclude provider, physician and payer organization names or
3832 codes and shall be kept confidential by the recipient. The [office] unit
3833 may release patient-identifiable data (1) for medical and scientific
3834 research as provided for in section 19a-25-3 of the regulations of
3835 Connecticut state agencies, and (2) to (A) a state agency for the
3836 purpose of improving health care service delivery, (B) a federal agency
3837 or the office of the Attorney General for the purpose of investigating
3838 hospital mergers and acquisitions, or (C) another state's health data
3839 collection agency with which the [office] unit has entered into a
3840 reciprocal data-sharing agreement for the purpose of certificate of need
3841 review or evaluation of health care services, upon receipt of a request
3842 from such agency, provided, prior to the release of such patient-
3843 identifiable data, such agency enters into a written agreement with the
3844 [office] unit pursuant to which such agency agrees to protect the
3845 confidentiality of such patient-identifiable data and not to use such
3846 patient-identifiable data as a basis for any decision concerning a
3847 patient. No individual or entity receiving patient-identifiable data may
3848 release such data in any manner that may result in an individual
3849 patient, physician, provider or payer being identified. The [office] unit
3850 shall impose a reasonable, cost-based fee for any patient data provided
3851 to a nongovernmental entity.

3852 (e) Not later than October 1, [2011] 2018, the [Office of Health Care
3853 Access] Health Systems Planning Unit shall enter into a memorandum

3854 of understanding with the Comptroller that shall permit the
3855 Comptroller to access the data set forth in subsections (b) and (c) of
3856 this section, provided the Comptroller agrees, in writing, to keep
3857 individual patient and provider data identified by proper name or
3858 personal identification code and submitted pursuant to this section
3859 confidential.

3860 (f) The [Commissioner of Public Health] executive director of the
3861 Office of Health Strategy shall adopt regulations, in accordance with
3862 the provisions of chapter 54, to carry out the provisions of this section.

3863 (g) The duties assigned to the [Department of Public Health] Office
3864 of Health Strategy under the provisions of this section shall be
3865 implemented within available appropriations.

3866 Sec. 95. Section 19a-659 of the general statutes is repealed and the
3867 following is substituted in lieu thereof (*Effective July 1, 2018*):

3868 As used in [this chapter] sections 19a-644, as amended by this act,
3869 19a-649, as amended by this act, 19a-670, as amended by this act, and
3870 19a-676, as amended by this act, unless the context otherwise requires:

3871 [(1) "Office" means the Office of Health Care Access division of the
3872 Department of Public Health;]

3873 (1) "Unit" means the Health Systems Planning Unit within the Office
3874 of Health Strategy, established under section 19a-612, as amended by
3875 this act;

3876 (2) "Hospital" means any hospital licensed as a short-term acute care
3877 general or children's hospital by the Department of Public Health,
3878 including John Dempsey Hospital of The University of Connecticut
3879 Health Center;

3880 (3) "Fiscal year" means the hospital fiscal year consisting of a twelve-
3881 month period commencing on October first and ending the following
3882 September thirtieth;

3883 (4) "Affiliate" means a person, entity or organization controlling,
3884 controlled by, or under common control with another person, entity or
3885 organization;

3886 (5) "Uncompensated care" means the total amount of charity care
3887 and bad debts determined by using the hospital's published charges
3888 and consistent with the hospital's policies regarding charity care and
3889 bad debts which are on file at the [office] unit;

3890 (6) "Medical assistance" means (A) the programs for medical
3891 assistance provided under the Medicaid program, including HUSKY
3892 A, or (B) any other state-funded medical assistance program, including
3893 HUSKY B;

3894 (7) "CHAMPUS" or "TriCare" means the federal Civilian Health and
3895 Medical Program of the Uniformed Services, as defined in 10 USC
3896 1072(4), as from time to time amended;

3897 (8) "Primary payer" means the payer responsible for the highest
3898 percentage of the charges for a patient's inpatient or outpatient
3899 hospital services;

3900 (9) "Case mix index" means the arithmetic mean of the Medicare
3901 diagnosis related group case weights assigned to each inpatient
3902 discharge for a specific hospital during a given fiscal year. The case
3903 mix index shall be calculated by dividing the hospital's total case mix
3904 adjusted discharges by the hospital's actual number of discharges for
3905 the fiscal year. The total case mix adjusted discharges shall be
3906 calculated by (A) multiplying the number of discharges in each
3907 diagnosis-related group by the Medicare weights in effect for that
3908 same diagnosis-related group and fiscal year, and (B) then totaling the
3909 resulting products for all diagnosis-related groups;

3910 (10) "Contractual allowances" means the difference between hospital
3911 published charges and payments generated by negotiated agreements
3912 for a different or discounted rate or method of payment;

3913 (11) "Medical assistance underpayment" means the amount

3914 calculated by dividing the total net revenue by the total gross revenue,
3915 and then multiplying the quotient by the total medical assistance
3916 charges, and then subtracting medical assistance payments from the
3917 product;

3918 (12) "Other allowances" means the amount of any difference
3919 between charges for employee self-insurance and related expenses
3920 determined using the hospital's overall relationship of costs to charges;

3921 (13) "Gross revenue" means the total gross patient charges for all
3922 patient services provided by a hospital; and

3923 (14) "Net revenue" means total gross revenue less contractual
3924 allowance, less the difference between government charges and
3925 government payments, less uncompensated care and other allowances.

3926 Sec. 96. Section 19a-670 of the general statutes is repealed and the
3927 following is substituted in lieu thereof (*Effective July 1, 2018*):

3928 The [office] unit shall, by September first of each year, report the
3929 results of the [office's] unit's review of the hospitals' annual and
3930 twelve-month filings under sections 19a-644, as amended by this act,
3931 19a-649, as amended by this act, and 19a-676, as amended by this act,
3932 for the previous hospital fiscal year to the joint standing committee of
3933 the General Assembly having cognizance of matters relating to public
3934 health. The report shall include information concerning the financial
3935 stability of hospitals in a competitive market.

3936 Sec. 97. Subdivision (1) of subsection (a) of section 19a-673 of the
3937 general statutes is repealed and the following is substituted in lieu
3938 thereof (*Effective July 1, 2018*):

3939 (1) "Cost of providing services" means a hospital's published
3940 charges at the time of billing, multiplied by the hospital's most recent
3941 relationship of costs to charges as taken from the hospital's most
3942 recently available annual financial filing with the [office] unit.

3943 Sec. 98. Section 19a-673a of the general statutes is repealed and the

3944 following is substituted in lieu thereof (*Effective July 1, 2018*):

3945 The [Commissioner of Public Health] executive director of the
3946 Office of Health Strategy shall adopt regulations, in accordance with
3947 chapter 54, to establish uniform debt collection standards for hospitals.

3948 Sec. 99. Section 19a-673c of the general statutes is repealed and the
3949 following is substituted in lieu thereof (*Effective July 1, 2018*):

3950 On or before March 1, 2004, and annually thereafter, each hospital
3951 shall file with the [office] unit a debt collection report that includes (1)
3952 whether the hospital uses a collection agent, as defined in section 19a-
3953 509b, as amended by this act, to assist with debt collection, (2) the
3954 name of any collection agent used, (3) the hospital's processes and
3955 policies for assigning a debt to a collection agent and for compensating
3956 such collection agent for services rendered, and (4) the recovery rate on
3957 accounts assigned to collection agents, exclusive of Medicare accounts,
3958 in the most recent hospital fiscal year.

3959 Sec. 100. Section 19a-676 of the general statutes is repealed and the
3960 following is substituted in lieu thereof (*Effective July 1, 2018*):

3961 On or before March thirty-first of each year, for the preceding fiscal
3962 year, each hospital shall submit to the [office] unit, in the form and
3963 manner prescribed by the [office] unit, the data specified in regulations
3964 adopted by the [commissioner] executive director in accordance with
3965 chapter 54, the hospital's verification of net revenue required under
3966 section 19a-649, as amended by this act, and any other data required
3967 by the [office] unit, including hospital budget system data for the
3968 hospital's twelve months' actual filing requirements.

3969 Sec. 101. Section 19a-681 of the general statutes is repealed and the
3970 following is substituted in lieu thereof (*Effective July 1, 2018*):

3971 (a) For purposes of this section: (1) "Detailed patient bill" means a
3972 patient billing statement that includes, in each line item, the hospital's
3973 current pricemaster code, a description of the charge and the billed
3974 amount; and (2) "pricemaster" means a detailed schedule of hospital

3975 charges.

3976 (b) Each hospital shall file with the [office] unit its current
3977 pricemaster which shall include each charge in its detailed schedule of
3978 charges.

3979 (c) Upon the request of the [Department of Public Health] Office of
3980 Health Strategy, established under section 19a-754a, as amended by
3981 this act, or a patient, a hospital shall provide to the [department] office
3982 or the patient a detailed patient bill. If the billing detail by line item on
3983 a detailed patient bill does not agree with the detailed schedule of
3984 charges on file with the [office] unit for the date of service specified on
3985 the bill, the hospital shall be subject to a civil penalty of five hundred
3986 dollars per occurrence payable to the state not later than fourteen days
3987 after the date of notification. The penalty shall be imposed in
3988 accordance with section 19a-653, as amended by this act. The [office]
3989 unit may issue an order requiring such hospital, not later than fourteen
3990 days after the date of notification of an overcharge to a patient, to
3991 adjust the bill to be consistent with the detailed schedule of charges on
3992 file with the [office] unit for the date of service specified on the
3993 detailed patient bill.

3994 Sec. 102. Section 19a-486 of the general statutes is repealed and the
3995 following is substituted in lieu thereof (*Effective July 1, 2018*):

3996 For purposes of sections 19a-486 to 19a-486h, inclusive, as amended
3997 by this act:

3998 (1) "Nonprofit hospital" means a nonprofit entity licensed as a
3999 hospital pursuant to this chapter and any entity affiliated with such a
4000 hospital through governance or membership, including, but not
4001 limited to, a holding company or subsidiary.

4002 (2) "Purchaser" means a person acquiring any assets of a nonprofit
4003 hospital through a transfer.

4004 (3) "Person" means any individual, firm, partnership, corporation,
4005 limited liability company, association or other entity.

4006 (4) "Transfer" means to sell, transfer, lease, exchange, option,
4007 convey, give or otherwise dispose of or transfer control over,
4008 including, but not limited to, transfer by way of merger or joint
4009 venture not in the ordinary course of business.

4010 (5) "Control" has the meaning assigned to it in section 36b-41.

4011 (6) ["Commissioner" means the Commissioner of Public Health or
4012 the commissioner's designee.] "Executive director" means the executive
4013 director of the Office of Health Strategy, established under section 19a-
4014 754a, as amended by this act, or the executive director's designee.

4015 Sec. 103. Section 19a-486a of the general statutes is repealed and the
4016 following is substituted in lieu thereof (*Effective July 1, 2018*):

4017 (a) No nonprofit hospital shall enter into an agreement to transfer a
4018 material amount of its assets or operations or a change in control of
4019 operations to a person that is organized or operated for profit without
4020 first having received approval of the agreement by the [commissioner]
4021 executive director and the Attorney General pursuant to sections 19a-
4022 486 to 19a-486h, inclusive, as amended by this act, and pursuant to the
4023 Attorney General's authority under section 3-125. Any such agreement
4024 without the approval required by sections 19a-486 to 19a-486h,
4025 inclusive, as amended by this act, shall be void.

4026 (b) Prior to any transaction described in subsection (a) of this
4027 section, the nonprofit hospital and the purchaser shall concurrently
4028 submit a certificate of need determination letter as described in
4029 subsection (c) of section 19a-638, as amended by this act, to the
4030 [commissioner] executive director and the Attorney General by serving
4031 it on them by certified mail, return receipt requested, or delivering it
4032 by hand to each office. The certificate of need determination letter shall
4033 contain: (1) The name and address of the nonprofit hospital; (2) the
4034 name and address of the purchaser; (3) a brief description of the terms
4035 of the proposed agreement; and (4) the estimated capital expenditure,
4036 cost or value associated with the proposed agreement. The certificate
4037 of need determination letter shall be subject to disclosure pursuant to

4038 section 1-210, as amended by this act.

4039 (c) Not later than thirty days after receipt of the certificate of need
4040 determination letter by the [commissioner] executive director and the
4041 Attorney General, the purchaser and the nonprofit hospital shall hold a
4042 hearing on the contents of the certificate of need determination letter in
4043 the municipality in which the new hospital is proposed to be located.
4044 The nonprofit hospital shall provide not less than two weeks' advance
4045 notice of the hearing to the public by publication in a newspaper
4046 having a substantial circulation in the affected community for not less
4047 than three consecutive days. Such notice shall contain substantially the
4048 same information as in the certificate of need determination letter. The
4049 purchaser and the nonprofit hospital shall record and transcribe the
4050 hearing and make such recording or transcription available to the
4051 [commissioner] executive director, the Attorney General or members
4052 of the public upon request. A public hearing held in accordance with
4053 the provisions of section 19a-639a, as amended by this act, shall satisfy
4054 the requirements of this subsection.

4055 (d) The [commissioner] executive director and the Attorney General
4056 shall review the certificate of need determination letter. The Attorney
4057 General shall determine whether the agreement requires approval
4058 pursuant to this chapter. If such approval is required, the
4059 [commissioner] executive director and the Attorney General shall
4060 transmit to the purchaser and the nonprofit hospital an application
4061 form for approval pursuant to this chapter, unless the [commissioner]
4062 executive director refuses to accept a filed or submitted certificate of
4063 need determination letter. Such application form shall require the
4064 following information: (1) The name and address of the nonprofit
4065 hospital; (2) the name and address of the purchaser; (3) a description of
4066 the terms of the proposed agreement; (4) copies of all contracts,
4067 agreements and memoranda of understanding relating to the proposed
4068 agreement; (5) a fairness evaluation by an independent person who is
4069 an expert in such agreements, that includes an analysis of each of the
4070 criteria set forth in section 19a-486c; (6) documentation that the
4071 nonprofit hospital exercised the due diligence required by subdivision

4072 (2) of subsection (a) of section 19a-486c, including disclosure of the
4073 terms of any other offers to transfer assets or operations or change
4074 control of operations received by the nonprofit hospital and the reason
4075 for rejection of such offers; and (7) such other information as the
4076 [commissioner] executive director or the Attorney General deem
4077 necessary to their review pursuant to the provisions of sections 19a-486
4078 to 19a-486f, inclusive, as amended by this act, and chapter 368z. The
4079 application shall be subject to disclosure pursuant to section 1-210, as
4080 amended by this act.

4081 (e) No later than sixty days after the date of mailing of the
4082 application form, the nonprofit hospital and the purchaser shall
4083 concurrently file an application with the [commissioner] executive
4084 director and the Attorney General containing all the required
4085 information. The [commissioner] executive director and the Attorney
4086 General shall review the application and determine whether the
4087 application is complete. The [commissioner] executive director and the
4088 Attorney General shall, no later than twenty days after the date of their
4089 receipt of the application, provide written notice to the nonprofit
4090 hospital and the purchaser of any deficiencies in the application. Such
4091 application shall not be deemed complete until such deficiencies are
4092 corrected.

4093 (f) No later than twenty-five days after the date of their receipt of
4094 the completed application under this section, the [commissioner]
4095 executive director and the Attorney General shall jointly publish a
4096 summary of such agreement in a newspaper of general circulation
4097 where the nonprofit hospital is located.

4098 (g) Any person may seek to intervene in the proceedings under
4099 section 19a-486e, as amended by this act, in the same manner as
4100 provided in section 4-177a.

4101 Sec. 104. Section 19a-486b of the general statutes is repealed and the
4102 following is substituted in lieu thereof (*Effective July 1, 2018*):

4103 (a) Not later than one hundred twenty days after the date of receipt

4104 of the completed application pursuant to subsection (e) of section 19a-
4105 486a, as amended by this act, the Attorney General and the
4106 [commissioner] executive director shall approve the application, with
4107 or without modification, or deny the application. The [commissioner]
4108 executive director shall also determine, in accordance with the
4109 provisions of chapter 368z, whether to approve, with or without
4110 modification, or deny the application for a certificate of need that is
4111 part of the completed application. Notwithstanding the provisions of
4112 section 19a-639a, as amended by this act, the [commissioner] executive
4113 director shall complete the decision on the application for a certificate
4114 of need within the same time period as the completed application.
4115 Such one-hundred-twenty-day period may be extended by (1)
4116 agreement of the Attorney General, the [commissioner] executive
4117 director, the nonprofit hospital and the purchaser, or (2) the
4118 [commissioner] executive director for an additional one hundred
4119 twenty days pending completion of a cost and market impact review
4120 conducted pursuant to section 19a-639f, as amended by this act. If the
4121 Attorney General initiates a proceeding to enforce a subpoena
4122 pursuant to section 19a-486c or 19a-486d, as amended by this act, the
4123 one-hundred-twenty-day period shall be tolled until the final court
4124 decision on the last pending enforcement proceeding, including any
4125 appeal or time for the filing of such appeal. Unless the one-hundred-
4126 twenty-day period is extended pursuant to this section, if the
4127 [commissioner] executive director and Attorney General fail to take
4128 action on an agreement prior to the one hundred twenty-first day after
4129 the date of the filing of the completed application, the application shall
4130 be deemed approved.

4131 (b) The [commissioner] executive director and the Attorney General
4132 may place any conditions on the approval of an application that relate
4133 to the purposes of sections 19a-486a to 19a-486h, inclusive, as amended
4134 by this act. In placing any such conditions the [commissioner]
4135 executive director shall follow the guidelines and criteria described in
4136 subdivision (4) of subsection (d) of section 19a-639, as amended by this
4137 act. Any such conditions may be in addition to any conditions placed
4138 by the [commissioner] executive director pursuant to subdivision (4) of

4139 subsection (d) of section 19a-639, as amended by this act.

4140 Sec. 105. Section 19a-486d of the general statutes is repealed and the
4141 following is substituted in lieu thereof (*Effective July 1, 2018*):

4142 (a) The [commissioner] executive director shall deny an application
4143 filed pursuant to subsection (d) of section 19a-486a, as amended by this
4144 act, unless the [commissioner] executive director finds that: (1) In a
4145 situation where the asset or operation to be transferred provides or has
4146 provided health care services to the uninsured or underinsured, the
4147 purchaser has made a commitment to provide health care to the
4148 uninsured and the underinsured; (2) in a situation where health care
4149 providers or insurers will be offered the opportunity to invest or own
4150 an interest in the purchaser or an entity related to the purchaser
4151 safeguard procedures are in place to avoid a conflict of interest in
4152 patient referral; and (3) certificate of need authorization is justified in
4153 accordance with chapter 368z. The [commissioner] executive director
4154 may contract with any person, including, but not limited to, financial
4155 or actuarial experts or consultants, or legal experts with the approval
4156 of the Attorney General, to assist in reviewing the completed
4157 application. The [commissioner] executive director shall submit any
4158 bills for such contracts to the purchaser. Such bills shall not exceed one
4159 hundred fifty thousand dollars. The purchaser shall pay such bills no
4160 later than thirty days after the date of receipt of such bills.

4161 (b) The [commissioner] executive director may, during the course of
4162 a review required by this section: (1) Issue in writing and cause to be
4163 served upon any person, by subpoena, a demand that such person
4164 appear before the [commissioner] executive director and give
4165 testimony or produce documents as to any matters relevant to the
4166 scope of the review; and (2) issue written interrogatories, to be
4167 answered under oath, as to any matters relevant to the scope of the
4168 review and prescribing a return date that would allow a reasonable
4169 time to respond. If any person fails to comply with the provisions of
4170 this subsection, the [commissioner] executive director, through the
4171 Attorney General, may apply to the superior court for the judicial

4172 district of Hartford seeking enforcement of such subpoena. The
4173 superior court may, upon notice to such person, issue and cause to be
4174 served an order requiring compliance. Service of subpoenas ad
4175 testificandum, subpoenas duces tecum, notices of deposition and
4176 written interrogatories as provided in this subsection may be made by
4177 personal service at the usual place of abode or by certified mail, return
4178 receipt requested, addressed to the person to be served at such
4179 person's principal place of business within or without this state or such
4180 person's residence.

4181 Sec. 106. Section 19a-486e of the general statutes is repealed and the
4182 following is substituted in lieu thereof (*Effective July 1, 2018*):

4183 Prior to making any decision to approve, with or without
4184 modification, or deny any application filed pursuant to subsection (d)
4185 of section 19a-486a, as amended by this act, the Attorney General and
4186 the [commissioner] executive director shall jointly conduct one or more
4187 public hearings, one of which shall be in the primary service area of
4188 the nonprofit hospital. At least fourteen days before conducting the
4189 public hearing, the Attorney General and the [commissioner] executive
4190 director shall provide notice of the time and place of the hearing
4191 through publication in one or more newspapers of general circulation
4192 in the affected community.

4193 Sec. 107. Section 19a-486f of the general statutes is repealed and the
4194 following is substituted in lieu thereof (*Effective July 1, 2018*):

4195 If the [commissioner] executive director or the Attorney General
4196 denies an application filed pursuant to subsection (d) of section 19a-
4197 486a, as amended by this act, or approves it with modification, the
4198 nonprofit hospital or the purchaser may appeal such decision in the
4199 same manner as provided in section 4-183, provided that nothing in
4200 sections 19a-486 to 19a-486f, inclusive, as amended by this act, shall be
4201 construed to apply the provisions of chapter 54 to the proceedings of
4202 the Attorney General.

4203 Sec. 108. Section 19a-486g of the general statutes is repealed and the

4204 following is substituted in lieu thereof (*Effective July 1, 2018*):

4205 The Commissioner of Public Health shall refuse to issue a license to,
4206 or if issued shall suspend or revoke the license of, a hospital if the
4207 commissioner finds, after a hearing and opportunity to be heard, that:

4208 (1) There was a transaction described in section 19a-486a, as
4209 amended by this act, that occurred without the approval of the
4210 [commissioner] executive director, if such approval was required by
4211 sections 19a-486 to 19a-486h, inclusive, as amended by this act;

4212 (2) There was a transaction described in section 19a-486a, as
4213 amended by this act, without the approval of the Attorney General, if
4214 such approval was required by sections 19a-486 to 19a-486h, inclusive,
4215 as amended by this act, and the Attorney General certifies to the
4216 [Commissioner of Public Health] executive director that such
4217 transaction involved a material amount of the nonprofit hospital's
4218 assets or operations or a change in control of operations; or

4219 (3) The hospital is not complying with the terms of an agreement
4220 approved by the Attorney General and [commissioner] executive
4221 director pursuant to sections 19a-486 to 19a-486h, inclusive, as
4222 amended by this act.

4223 Sec. 109. Section 19a-486h of the general statutes is repealed and the
4224 following is substituted in lieu thereof (*Effective July 1, 2018*):

4225 Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by
4226 this act, shall be construed to limit: (1) The common law or statutory
4227 authority of the Attorney General; (2) the statutory authority of the
4228 Commissioner of Public Health including, but not limited to, licensing;
4229 [and] (3) the statutory authority of the executive director of the Office
4230 of Health Strategy, including, but not limited to, certificate of need
4231 authority; or [(3)] (4) the application of the doctrine of cy pres or
4232 approximation.

4233 Sec. 110. Subsections (d) to (i), inclusive, of section 19a-486i of the
4234 2018 supplement to the general statutes are repealed and the following

4235 is substituted in lieu thereof (*Effective July 1, 2018*):

4236 (d) (1) The written notice required under subsection (c) of this
4237 section shall identify each party to the transaction and describe the
4238 material change as of the date of such notice to the business or
4239 corporate structure of the group practice, including: (A) A description
4240 of the nature of the proposed relationship among the parties to the
4241 proposed transaction; (B) the names and specialties of each physician
4242 that is a member of the group practice that is the subject of the
4243 proposed transaction and who will practice medicine with the
4244 resulting group practice, hospital, hospital system, captive professional
4245 entity, medical foundation or other entity organized by, controlled by,
4246 or otherwise affiliated with such hospital or hospital system following
4247 the effective date of the transaction; (C) the names of the business
4248 entities that are to provide services following the effective date of the
4249 transaction; (D) the address for each location where such services are
4250 to be provided; (E) a description of the services to be provided at each
4251 such location; and (F) the primary service area to be served by each
4252 such location.

4253 (2) Not later than thirty days after the effective date of any
4254 transaction described in subsection (c) of this section, the parties to the
4255 transaction shall submit written notice to the [Commissioner of Public
4256 Health] executive director of the Office of Health Strategy. Such
4257 written notice shall include, but need not be limited to, the same
4258 information described in subdivision (1) of this subsection. The
4259 [commissioner] executive director shall post a link to such notice on
4260 the [Department of Public Health's] Office of Health Strategy's Internet
4261 web site.

4262 (e) Not less than thirty days prior to the effective date of any
4263 transaction that results in an affiliation between one hospital or
4264 hospital system and another hospital or hospital system, the parties to
4265 the affiliation shall submit written notice to the Attorney General of
4266 such affiliation. Such written notice shall identify each party to the
4267 affiliation and describe the affiliation as of the date of such notice,

4268 including: (1) A description of the nature of the proposed relationship
4269 among the parties to the affiliation; (2) the names of the business
4270 entities that are to provide services following the effective date of the
4271 affiliation; (3) the address for each location where such services are to
4272 be provided; (4) a description of the services to be provided at each
4273 such location; and (5) the primary service area to be served by each
4274 such location.

4275 (f) Written information submitted to the Attorney General pursuant
4276 to subsections (b) to (e), inclusive, of this section shall be maintained
4277 and used by the Attorney General in the same manner as provided in
4278 section 35-42.

4279 (g) Not later than January 15, 2018, and annually thereafter, each
4280 hospital and hospital system shall file with the Attorney General and
4281 the [Commissioner of Public Health] executive director of the Office of
4282 Health Strategy a written report describing the activities of the group
4283 practices owned or affiliated with such hospital or hospital system.
4284 Such report shall include, for each such group practice: (1) A
4285 description of the nature of the relationship between the hospital or
4286 hospital system and the group practice; (2) the names and specialties of
4287 each physician practicing medicine with the group practice; (3) the
4288 names of the business entities that provide services as part of the
4289 group practice and the address for each location where such services
4290 are provided; (4) a description of the services provided at each such
4291 location; and (5) the primary service area served by each such location.

4292 (h) Not later than January 15, 2018, and annually thereafter, each
4293 group practice comprised of thirty or more physicians that is not the
4294 subject of a report filed under subsection (g) of this section shall file
4295 with the Attorney General and the [Commissioner of Public Health]
4296 executive director of the Office of Health Strategy a written report
4297 concerning the group practice. Such report shall include, for each such
4298 group practice: (1) The names and specialties of each physician
4299 practicing medicine with the group practice; (2) the names of the
4300 business entities that provide services as part of the group practice and

4301 the address for each location where such services are provided; (3) a
4302 description of the services provided at each such location; and (4) the
4303 primary service area served by each such location.

4304 (i) Not later than January 15, 2018, and annually thereafter, each
4305 hospital and hospital system shall file with the Attorney General and
4306 the [Commissioner of Public Health] executive director of the Office of
4307 Health Strategy a written report describing each affiliation with
4308 another hospital or hospital system. Such report shall include: (1) The
4309 name and address of each party to the affiliation; (2) a description of
4310 the nature of the relationship among the parties to the affiliation; (3)
4311 the names of the business entities that provide services as part of the
4312 affiliation and the address for each location where such services are
4313 provided; (4) a description of the services provided at each such
4314 location; and (5) the primary service area served by each such location.

4315 Sec. 111. Subsections (j) to (m), inclusive, of section 19a-508c of the
4316 2018 supplement to the general statutes are repealed and the following
4317 is substituted in lieu thereof (*Effective July 1, 2018*):

4318 (j) A hospital-based facility shall, when scheduling services for
4319 which a facility fee may be charged, inform the patient (1) that the
4320 hospital-based facility is part of a hospital or health system, (2) of the
4321 name of the hospital or health system, (3) that the hospital or health
4322 system may charge a facility fee in addition to and separate from the
4323 professional fee charged by the provider, and (4) of the telephone
4324 number the patient may call for additional information regarding such
4325 patient's potential financial liability.

4326 (k) (1) On and after January 1, 2016, if any transaction, as described
4327 in subsection (c) of section 19a-486i, as amended by this act, results in
4328 the establishment of a hospital-based facility at which facility fees will
4329 likely be billed, the hospital or health system, that is the purchaser in
4330 such transaction shall, not later than thirty days after such transaction,
4331 provide written notice, by first class mail, of the transaction to each
4332 patient served within the previous three years by the health care
4333 facility that has been purchased as part of such transaction.

4334 (2) Such notice shall include the following information:

4335 (A) A statement that the health care facility is now a hospital-based
4336 facility and is part of a hospital or health system;

4337 (B) The name, business address and phone number of the hospital
4338 or health system that is the purchaser of the health care facility;

4339 (C) A statement that the hospital-based facility bills, or is likely to
4340 bill, patients a facility fee that may be in addition to, and separate
4341 from, any professional fee billed by a health care provider at the
4342 hospital-based facility;

4343 (D) (i) A statement that the patient's actual financial liability will
4344 depend on the professional medical services actually provided to the
4345 patient, and (ii) an explanation that the patient may incur financial
4346 liability that is greater than the patient would incur if the hospital-
4347 based facility were not a hospital-based facility;

4348 (E) The estimated amount or range of amounts the hospital-based
4349 facility may bill for a facility fee or an example of the average facility
4350 fee billed at such hospital-based facility for the most common services
4351 provided at such hospital-based facility; and

4352 (F) A statement that, prior to seeking services at such hospital-based
4353 facility, a patient covered by a health insurance policy should contact
4354 the patient's health insurer for additional information regarding the
4355 hospital-based facility fees, including the patient's potential financial
4356 liability, if any, for such fees.

4357 (3) A copy of the written notice provided to patients in accordance
4358 with this subsection shall be filed with the [Office of Health Care
4359 Access] Health Systems Planning Unit of the Office of Health Strategy,
4360 established under section 19a-612, as amended by this act. Said [office]
4361 unit shall post a link to such notice on its Internet web site.

4362 (4) A hospital, health system or hospital-based facility shall not
4363 collect a facility fee for services provided at a hospital-based facility

4364 that is subject to the provisions of this subsection from the date of the
4365 transaction until at least thirty days after the written notice required
4366 pursuant to this subsection is mailed to the patient or a copy of such
4367 notice is filed with the [Office of Health Care Access] Health Systems
4368 Planning Unit, whichever is later. A violation of this subsection shall
4369 be considered an unfair trade practice pursuant to section 42-110b.

4370 (l) Notwithstanding the provisions of this section, on and after
4371 January 1, 2017, no hospital, health system or hospital-based facility
4372 shall collect a facility fee for (1) outpatient health care services that use
4373 a current procedural terminology evaluation and management code
4374 and are provided at a hospital-based facility, other than a hospital
4375 emergency department, located off-site from a hospital campus, or (2)
4376 outpatient health care services, other than those provided in an
4377 emergency department located off-site from a hospital campus,
4378 received by a patient who is uninsured of more than the Medicare rate.
4379 Notwithstanding the provisions of this subsection, in circumstances
4380 when an insurance contract that is in effect on July 1, 2016, provides
4381 reimbursement for facility fees prohibited under the provisions of this
4382 section, a hospital or health system may continue to collect
4383 reimbursement from the health insurer for such facility fees until the
4384 date of expiration of such contract. A violation of this subsection shall
4385 be considered an unfair trade practice pursuant to chapter 735a.

4386 (m) (1) Each hospital and health system shall report not later than
4387 July 1, 2016, and annually thereafter to the [Commissioner of Public
4388 Health] executive director of the Office of Health Strategy concerning
4389 facility fees charged or billed during the preceding calendar year. Such
4390 report shall include (A) the name and location of each facility owned
4391 or operated by the hospital or health system that provides services for
4392 which a facility fee is charged or billed, (B) the number of patient visits
4393 at each such facility for which a facility fee was charged or billed, (C)
4394 the number, total amount and range of allowable facility fees paid at
4395 each such facility by Medicare, Medicaid or under private insurance
4396 policies, (D) for each facility, the total amount of revenue received by
4397 the hospital or health system derived from facility fees, (E) the total

4398 amount of revenue received by the hospital or health system from all
4399 facilities derived from facility fees, (F) a description of the ten
4400 procedures or services that generated the greatest amount of facility
4401 fee revenue and, for each such procedure or service, the total amount
4402 of revenue received by the hospital or health system derived from
4403 facility fees, and (G) the top ten procedures for which facility fees are
4404 charged based on patient volume. For purposes of this subsection,
4405 "facility" means a hospital-based facility that is located outside a
4406 hospital campus.

4407 (2) The [commissioner] executive director shall publish the
4408 information reported pursuant to subdivision (1) of this subsection, or
4409 post a link to such information, on the Internet web site of the Office of
4410 Health [Care Access] Strategy.

4411 Sec. 112. Subsections (c) to (f), inclusive, of section 19a-509b of the
4412 general statutes are repealed and the following is substituted in lieu
4413 thereof (*Effective July 1, 2018*):

4414 (c) Each hospital that holds or administers one or more hospital bed
4415 funds shall make available in a place and manner allowing individual
4416 members of the public to easily obtain it, a one-page summary in
4417 English and Spanish describing hospital bed funds and how to apply
4418 for them. The summary shall also describe any other policies regarding
4419 the provision of charity care and reduced cost services for the indigent
4420 as reported by the hospital to the [Office of Health Care Access
4421 division of the Department of Public Health] Health Systems Planning
4422 Unit of the Office of Health Strategy pursuant to section 19a-649, as
4423 amended by this act, and shall clearly distinguish hospital bed funds
4424 from other sources of financial assistance. The summary shall include
4425 notification that the patient is entitled to reapply upon rejection, and
4426 that additional funds may become available on an annual basis. The
4427 summary shall be available in the patient admissions office, emergency
4428 room, social services department and patient accounts or billing office,
4429 and from any collection agent. If during the admission process or
4430 during its review of the financial resources of the patient, the hospital

4431 reasonably believes the patient will have limited funds to pay for any
4432 portion of the patient's hospitalization not covered by insurance, the
4433 hospital shall provide the summary to each such patient.

4434 (d) Each hospital which holds or administers one or more hospital
4435 bed funds shall require its collection agents to include a summary as
4436 provided in subsection (c) of this section in all bills and collection
4437 notices sent by such collection agents.

4438 (e) Applicants for assistance from hospital bed funds shall be
4439 notified in writing of any award or any rejection and the reason for
4440 such rejection. Patients who cannot pay any outstanding medical bill at
4441 the hospital shall be allowed to apply or reapply for hospital bed
4442 funds.

4443 (f) Each hospital which holds or administers one or more hospital
4444 bed funds shall maintain and annually compile, at the end of the fiscal
4445 year of the hospital, the following information: (1) The number of
4446 applications for hospital bed funds; (2) the number of patients
4447 receiving hospital bed fund grants and the actual dollar amounts
4448 provided to each patient from such fund; (3) the fair market value of
4449 the principal of each individual hospital bed fund, or the principal
4450 attributable to each bed fund if held in a pooled investment; (4) the
4451 total earnings for each hospital bed fund or the earnings attributable to
4452 each hospital bed fund; (5) the dollar amount of earnings reinvested as
4453 principal if any; and (6) the dollar amount of earnings available for
4454 patient care. The information compiled pursuant to this subsection
4455 shall be permanently retained by the hospital and made available to
4456 the [Office of Health Care Access] Health Systems Planning Unit upon
4457 request.

4458 Sec. 113. Subsections (e) to (g), inclusive, of section 33-182bb of the
4459 general statutes are repealed and the following is substituted in lieu
4460 thereof (*Effective July 1, 2018*):

4461 (e) Any medical foundation organized on or after July 1, 2009, shall
4462 file a copy of its certificate of incorporation and any amendments to its

4463 certificate of incorporation with the [Office of Health Care Access
4464 division of the Department of Public Health] Health Systems Planning
4465 Unit of the Office of Health Strategy not later than ten business days
4466 after the medical foundation files such certificate of incorporation or
4467 amendment with the Secretary of the State pursuant to chapter 602.

4468 (f) Any medical group clinic corporation formed under chapter 594
4469 of the general statutes, revision of 1958, revised to 1995, which amends
4470 its certificate of incorporation pursuant to subsection (a) of section 33-
4471 182cc, shall file with the [Office of Health Care Access division of the
4472 Department of Public Health] Health Systems Planning Unit of the
4473 Office of Health Strategy a copy of its certificate of incorporation and
4474 any amendments to its certificate of incorporation, including any
4475 amendment to its certificate of incorporation that complies with the
4476 requirements of subsection (a) of section 33-182cc, not later than ten
4477 business days after the medical foundation files its certificate of
4478 incorporation or any amendments to its certificate of incorporation
4479 with the Secretary of the State.

4480 (g) Any medical foundation, regardless of when organized, shall file
4481 notice with the [Office of Health Care Access division of the
4482 Department of Public Health] Health Systems Planning Unit of the
4483 Office of Health Strategy and the Secretary of the State of its
4484 liquidation, termination, dissolution or cessation of operations not later
4485 than ten business days after a vote by its board of directors or
4486 members to take such action. A medical foundation shall, annually,
4487 provide the office with (1) a statement of its mission, (2) the name and
4488 address of the organizing members, (3) the name and specialty of each
4489 physician employed by or acting as an agent of the medical
4490 foundation, (4) the location or locations where each such physician
4491 practices, (5) a description of the services provided at each such
4492 location, (6) a description of any significant change in its services
4493 during the preceding year, (7) a copy of the medical foundation's
4494 governing documents and bylaws, (8) the name and employer of each
4495 member of the board of directors, and (9) other financial information
4496 as reported on the medical foundation's most recently filed Internal

4497 Revenue Service return of organization exempt from income tax form,
4498 or any replacement form adopted by the Internal Revenue Service, or,
4499 if such medical foundation is not required to file such form,
4500 information substantially similar to that required by such form. The
4501 [Office of Health Care Access] Health Systems Planning Unit shall
4502 make such forms and information available to members of the public
4503 and accessible on said [office's] unit's Internet web site.

4504 Sec. 114. Subsections (b) and (c) of section 19a-493b of the general
4505 statutes are repealed and the following is substituted in lieu thereof
4506 (*Effective July 1, 2018*):

4507 (b) No entity, individual, firm, partnership, corporation, limited
4508 liability company or association, other than a hospital, shall
4509 individually or jointly establish or operate an outpatient surgical
4510 facility in this state without complying with chapter 368z, except as
4511 otherwise provided by this section, and obtaining a license within the
4512 time specified in this subsection from the Department of Public Health
4513 for such facility pursuant to the provisions of this chapter, unless such
4514 entity, individual, firm, partnership, corporation, limited liability
4515 company or association: (1) Provides to the [Office of Health Care
4516 Access division of the Department of Public Health] Health Systems
4517 Planning Unit of the Office of Health Strategy satisfactory evidence
4518 that it was in operation on or before July 1, 2003, or (2) obtained, on or
4519 before July 1, 2003, from the Office of Health Care Access, a
4520 determination that a certificate of need is not required. An entity,
4521 individual, firm, partnership, corporation, limited liability company or
4522 association otherwise in compliance with this section may operate an
4523 outpatient surgical facility without a license through March 30, 2007,
4524 and shall have until March 30, 2007, to obtain a license from the
4525 Department of Public Health.

4526 (c) Notwithstanding the provisions of this section, no outpatient
4527 surgical facility shall be required to comply with section 19a-631, as
4528 amended by this act, 19a-632, as amended by this act, 19a-644, as
4529 amended by this act, 19a-645, as amended by this act, 19a-646, as

4530 amended by this act, 19a-649, as amended by this act, 19a-664 to 19a-
4531 666, inclusive, 19a-673 to 19a-676, inclusive, as amended by this act,
4532 19a-678, 19a-681, as amended by this act, or 19a-683. Each outpatient
4533 surgical facility shall continue to be subject to the obligations and
4534 requirements applicable to such facility, including, but not limited to,
4535 any applicable provision of this chapter and those provisions of
4536 chapter 368z not specified in this subsection, except that a request for
4537 permission to undertake a transfer or change of ownership or control
4538 shall not be required pursuant to subsection (a) of section 19a-638, as
4539 amended by this act, if the [Office of Health Care Access division of the
4540 Department of Public Health] Health Systems Planning Unit of the
4541 Office of Health Strategy determines that the following conditions are
4542 satisfied: (1) Prior to any such transfer or change of ownership or
4543 control, the outpatient surgical facility shall be owned and controlled
4544 exclusively by persons licensed pursuant to section 20-13 or chapter
4545 375, either directly or through a limited liability company, formed
4546 pursuant to chapter 613, a corporation, formed pursuant to chapters
4547 601 and 602, or a limited liability partnership, formed pursuant to
4548 chapter 614, that is exclusively owned by persons licensed pursuant to
4549 section 20-13 or chapter 375, or is under the interim control of an estate
4550 executor or conservator pending transfer of an ownership interest or
4551 control to a person licensed under section 20-13 or chapter 375, and (2)
4552 after any such transfer or change of ownership or control, persons
4553 licensed pursuant to section 20-13 or chapter 375, a limited liability
4554 company, formed pursuant to chapter 613, a corporation, formed
4555 pursuant to chapters 601 and 602, or a limited liability partnership,
4556 formed pursuant to chapter 614, that is exclusively owned by persons
4557 licensed pursuant to section 20-13 or chapter 375, shall own and
4558 control no less than a sixty per cent interest in the outpatient surgical
4559 facility.

4560 Sec. 115. Section 19a-6q of the general statutes is repealed and the
4561 following is substituted in lieu thereof (*Effective July 1, 2018*):

4562 (a) The Commissioner of Public Health, in consultation with the
4563 [Lieutenant Governor, or the Lieutenant Governor's designee]

4564 executive director of the Office of Health Strategy, established under
4565 section 19a-754a, as amended by this act, and local and regional health
4566 departments, shall, within available resources, develop a plan that is
4567 consistent with the Department of Public Health's Healthy Connecticut
4568 2020 health improvement plan and the state healthcare innovation
4569 plan developed pursuant to the State Innovation Model Initiative by
4570 the Centers for Medicare and Medicaid Services Innovation Center.
4571 The commissioner shall develop and implement such plan to: (1)
4572 Reduce the incidence of chronic disease, including, but not limited to,
4573 chronic cardiovascular disease, cancer, lupus, stroke, chronic lung
4574 disease, diabetes, arthritis or another chronic metabolic disease and the
4575 effects of behavioral health disorders; (2) improve chronic disease care
4576 coordination in the state; and (3) reduce the incidence and effects of
4577 chronic disease and improve outcomes for conditions associated with
4578 chronic disease in the state.

4579 (b) The commissioner shall, on or before January 15, 2015, and
4580 biennially thereafter, submit a report, in consultation with the
4581 [Lieutenant Governor or the Lieutenant Governor's designee]
4582 executive director of the Office of Health Strategy, in accordance with
4583 the provisions of section 11-4a to the joint standing committee of the
4584 General Assembly having cognizance of matters relating to public
4585 health concerning chronic disease and implementation of the plan
4586 described in subsection (a) of this section. The commissioner shall post
4587 each report on the Department of Public Health's Internet web site not
4588 later than thirty days after submitting such report. Each report shall
4589 include, but need not be limited to: (1) A description of the chronic
4590 diseases that are most likely to cause a person's death or disability, the
4591 approximate number of persons affected by such chronic diseases and
4592 an assessment of the financial effects of each such disease on the state
4593 and on hospitals and health care facilities; (2) a description and
4594 assessment of programs and actions that have been implemented by
4595 the department and health care providers to improve chronic disease
4596 care coordination and prevent chronic disease; (3) the sources and
4597 amounts of funding received by the department to treat persons with
4598 multiple chronic diseases and to treat or reduce the most prevalent

4599 chronic diseases in the state; (4) a description of chronic disease care
4600 coordination between the department and health care providers, to
4601 prevent and treat chronic disease; and (5) recommendations
4602 concerning actions that health care providers and persons with chronic
4603 disease may take to reduce the incidence and effects of chronic disease.

4604 Sec. 116. Section 19a-725 of the 2018 supplement to the general
4605 statutes is repealed and the following is substituted in lieu thereof
4606 (*Effective July 1, 2018*):

4607 (a) There is established within the [office of the Lieutenant
4608 Governor] Office of Health Strategy, established under section 19a-
4609 754a, as amended by this act, the Health Care Cabinet for the purpose
4610 of advising the Governor on the matters set forth in subsection (c) of
4611 this section.

4612 (b) (1) The Health Care Cabinet shall consist of the following
4613 members who shall be appointed on or before August 1, 2011: (A) Five
4614 appointed by the Governor, two of whom may represent the health
4615 care industry and shall serve for terms of four years, one of whom
4616 shall represent community health centers and shall serve for a term of
4617 three years, one of whom shall represent insurance producers and
4618 shall serve for a term of three years and one of whom shall be an at-
4619 large appointment and shall serve for a term of three years; (B) one
4620 appointed by the president pro tempore of the Senate, who shall be an
4621 oral health specialist engaged in active practice and shall serve for a
4622 term of four years; (C) one appointed by the majority leader of the
4623 Senate, who shall represent labor and shall serve for a term of three
4624 years; (D) one appointed by the minority leader of the Senate, who
4625 shall be an advanced practice registered nurse engaged in active
4626 practice and shall serve for a term of two years; (E) one appointed by
4627 the speaker of the House of Representatives, who shall be a consumer
4628 advocate and shall serve for a term of four years; (F) one appointed by
4629 the majority leader of the House of Representatives, who shall be a
4630 primary care physician engaged in active practice and shall serve for a
4631 term of four years; (G) one appointed by the minority leader of the

4632 House of Representatives, who shall represent the health information
4633 technology industry and shall serve for a term of three years; (H) five
4634 appointed jointly by the chairpersons of the Sustinet Health
4635 Partnership board of directors, one of whom shall represent faith
4636 communities, one of whom shall represent small businesses, one of
4637 whom shall represent the home health care industry, one of whom
4638 shall represent hospitals, and one of whom shall be an at-large
4639 appointment, all of whom shall serve for terms of five years; (I) the
4640 [Lieutenant Governor] executive director of the Office of Health
4641 Strategy, or the executive director's designee; (J) the Secretary of the
4642 Office of Policy and Management, or the secretary's designee; the
4643 Comptroller, or the Comptroller's designee; the chief executive officer
4644 of the Connecticut Health Insurance Exchange, or said officer's
4645 designee; the Commissioners of Social Services and Public Health, or
4646 their designees; and the Healthcare Advocate, or the Healthcare
4647 Advocate's designee, all of whom shall serve as ex-officio voting
4648 members; and (K) the Commissioners of Children and Families,
4649 Developmental Services and Mental Health and Addiction Services,
4650 and the Insurance Commissioner, or their designees, and the nonprofit
4651 liaison to the Governor, or the nonprofit liaison's designee, all of whom
4652 shall serve as ex-officio nonvoting members.

4653 (2) Following the expiration of initial cabinet member terms,
4654 subsequent cabinet terms shall be for four years, commencing on
4655 August first of the year of the appointment. If an appointing authority
4656 fails to make an initial appointment to the cabinet or an appointment
4657 to fill a cabinet vacancy within ninety days of the date of such vacancy,
4658 the appointed cabinet members shall, by majority vote, make such
4659 appointment to the cabinet.

4660 (3) Upon the expiration of the initial terms of the five cabinet
4661 members appointed by Sustinet Health Partnership board of directors,
4662 five successor cabinet members shall be appointed as follows: (A) One
4663 appointed by the Governor; (B) one appointed by the president pro
4664 tempore of the Senate; (C) one appointed by the speaker of the House
4665 of Representatives; and (D) two appointed by majority vote of the

4666 appointed board members. Successor board members appointed
4667 pursuant to this subdivision shall be at-large appointments.

4668 (4) The [Lieutenant Governor] executive director of the Office of
4669 Health Strategy, or the executive director's designee, shall serve as the
4670 chairperson of the Health Care Cabinet.

4671 (c) The Health Care Cabinet shall advise the Governor regarding the
4672 development of an integrated health care system for Connecticut and
4673 shall:

4674 (1) Evaluate the means of ensuring an adequate health care
4675 workforce in the state;

4676 (2) Jointly evaluate, with the chief executive officer of the
4677 Connecticut Health Insurance Exchange, the feasibility of
4678 implementing a basic health program option as set forth in Section
4679 1331 of the Affordable Care Act;

4680 (3) Identify short and long-range opportunities, issues and gaps
4681 created by the enactment of federal health care reform;

4682 (4) Review the effectiveness of delivery system reforms and other
4683 efforts to control health care costs, including, but not limited to,
4684 reforms and efforts implemented by state agencies; and

4685 (5) Advise the Governor on matters relating to: (A) The design,
4686 implementation, actionable objectives and evaluation of state and
4687 federal health care policies, priorities and objectives relating to the
4688 state's efforts to improve access to health care, (B) the quality of such
4689 care and the affordability and sustainability of the state's health care
4690 system, and (C) total state-wide health care spending, including
4691 methods to collect, analyze and report health care spending data.

4692 (d) The Health Care Cabinet may convene working groups, which
4693 include volunteer health care experts, to make recommendations
4694 concerning the development and implementation of service delivery
4695 and health care provider payment reforms, including multipayer

4696 initiatives, medical homes, electronic health records and evidenced-
4697 based health care quality improvement.

4698 (e) The [office of the Lieutenant Governor and the Office of the
4699 Healthcare Advocate] Office of Health Strategy shall provide support
4700 staff to the Health Care Cabinet.

4701 Sec. 117. Section 20-195sss of the 2018 supplement to the general
4702 statutes is repealed and the following is substituted in lieu thereof
4703 (*Effective July 1, 2018*):

4704 (a) As used in this section, "community health worker" means a
4705 public health outreach professional with an in-depth understanding of
4706 the experience, language, culture and socioeconomic needs of the
4707 community who (1) serves as a liaison between individuals within the
4708 community and health care and social services providers to facilitate
4709 access to such services and health-related resources, improve the
4710 quality and cultural competence of the delivery of such services and
4711 address social determinants of health with a goal toward reducing
4712 racial, ethnic, gender and socioeconomic health disparities, and (2)
4713 increases health knowledge and self-sufficiency through a range of
4714 services including outreach, engagement, education, coaching,
4715 informal counseling, social support, advocacy, care coordination,
4716 research related to social determinants of health and basic screenings
4717 and assessments of any risks associated with social determinants of
4718 health.

4719 (b) The executive director of the [state innovation model initiative
4720 program management office] Office of Health Strategy, established
4721 under section 19a-754a, as amended by this act, shall, within available
4722 resources and in consultation with the Community Health Worker
4723 Advisory Committee established by [such] said office and the
4724 Commissioner of Public Health, study the feasibility of creating a
4725 certification program for community health workers. Such study shall
4726 examine the fiscal impact of implementing such a certification program
4727 and include recommendations for (1) requirements for certification
4728 and renewal of certification of community health workers, including

4729 any training, experience or continuing education requirements, (2)
4730 methods for administering a certification program, including a
4731 certification application, a standardized assessment of experience,
4732 knowledge and skills, and an electronic registry, and (3) requirements
4733 for recognizing training program curricula that are sufficient to satisfy
4734 the requirements of certification.

4735 (c) Not later than October 1, 2018, the executive director of the [state
4736 innovation model initiative program management office] Office of
4737 Health Strategy shall report, in accordance with the provisions of
4738 section 11-4a, on the results of such study and recommendations to the
4739 joint standing committees of the General Assembly having cognizance
4740 of matters relating to public health and human services.

4741 Sec. 118. Section 38a-47 of the 2018 supplement to the general
4742 statutes is repealed and the following is substituted in lieu thereof
4743 (*Effective July 1, 2018*):

4744 (a) All domestic insurance companies and other domestic entities
4745 subject to taxation under chapter 207 shall, in accordance with section
4746 38a-48, as amended by this act, annually pay to the Insurance
4747 Commissioner, for deposit in the Insurance Fund established under
4748 section 38a-52a, an amount equal to: [the]

4749 (1) The actual expenditures made by the Insurance Department
4750 during each fiscal year, and the actual expenditures made by the Office
4751 of the Healthcare Advocate, including the cost of fringe benefits for
4752 department and office personnel as estimated by the Comptroller; [,
4753 plus (1) the]

4754 (2) The amount appropriated to the Office of Health Strategy from
4755 the Insurance Fund for the fiscal year, including the cost of fringe
4756 benefits for office personnel as estimated by the Comptroller;

4757 (3) The expenditures made on behalf of the department and [the
4758 office] said offices from the Capital Equipment Purchase Fund
4759 pursuant to section 4a-9 for such year, [and (2) the] but excluding such

4760 estimated expenditures made on behalf of the Health Systems
4761 Planning Unit of the Office of Health Strategy; and

4762 (4) The amount appropriated to the Department of Social Services
4763 for the fall prevention program established in section 17a-303a from
4764 the Insurance Fund for the fiscal year. [, but excluding]

4765 (b) The expenditures and amounts specified in subdivisions (1) to
4766 (4), inclusive, of subsection (a) of this section shall exclude
4767 expenditures paid for by fraternal benefit societies, foreign and alien
4768 insurance companies and other foreign and alien entities under
4769 sections 38a-49 and 38a-50.

4770 (c) Payments shall be made by assessment of all such domestic
4771 insurance companies and other domestic entities calculated and
4772 collected in accordance with the provisions of section 38a-48, as
4773 amended by this act. Any such domestic insurance company or other
4774 domestic entity aggrieved because of any assessment levied under this
4775 section may appeal therefrom in accordance with the provisions of
4776 section 38a-52.

4777 Sec. 119. Section 38a-48 of the 2018 supplement to the general
4778 statutes is repealed and the following is substituted in lieu thereof
4779 (*Effective July 1, 2018*):

4780 (a) On or before June thirtieth, annually, the Commissioner of
4781 Revenue Services shall render to the Insurance Commissioner a
4782 statement certifying the amount of taxes or charges imposed on each
4783 domestic insurance company or other domestic entity under chapter
4784 207 on business done in this state during the preceding calendar year.
4785 The statement for local domestic insurance companies shall set forth
4786 the amount of taxes and charges before any tax credits allowed as
4787 provided in subsection (a) of section 12-202.

4788 (b) On or before July thirty-first, annually, the Insurance
4789 Commissioner and the Office of the Healthcare Advocate shall render
4790 to each domestic insurance company or other domestic entity liable for

4791 payment under section 38a-47, as amended by this act: (1) A statement
4792 that includes (A) the amount appropriated to the Insurance
4793 Department, [and] the Office of the Healthcare Advocate and the
4794 Office of Health Strategy from the Insurance Fund established under
4795 section 38a-52a for the fiscal year beginning July first of the same year,
4796 (B) the cost of fringe benefits for department and office personnel for
4797 such year, as estimated by the Comptroller, (C) the estimated
4798 expenditures on behalf of the department and the [office] offices from
4799 the Capital Equipment Purchase Fund pursuant to section 4a-9 for
4800 such year, not including such estimated expenditures made on behalf
4801 of the Health Systems Planning Unit of the Office of Health Strategy,
4802 and (D) the amount appropriated to the Department of Social Services
4803 for the fall prevention program established in section 17a-303a from
4804 the Insurance Fund for the fiscal year; (2) a statement of the total taxes
4805 imposed on all domestic insurance companies and domestic insurance
4806 entities under chapter 207 on business done in this state during the
4807 preceding calendar year; and (3) the proposed assessment against that
4808 company or entity, calculated in accordance with the provisions of
4809 subsection (c) of this section, provided for the purposes of this
4810 calculation the amount appropriated to the Insurance Department,
4811 [and] the Office of the Healthcare Advocate and the Office of Health
4812 Strategy from the Insurance Fund plus the cost of fringe benefits for
4813 department and office personnel and the estimated expenditures on
4814 behalf of the department and the office from the Capital Equipment
4815 Purchase Fund pursuant to section 4a-9, not including such
4816 expenditures made on behalf of the Health Systems Planning Unit of
4817 the Office of Health Strategy shall be deemed to be the actual
4818 expenditures of the department and the office, and the amount
4819 appropriated to the Department of Social Services from the Insurance
4820 Fund for the fiscal year for the fall prevention program established in
4821 section 17a-303a shall be deemed to be the actual expenditures for the
4822 program.

4823 (c) (1) The proposed assessments for each domestic insurance
4824 company or other domestic entity shall be calculated by (A) allocating
4825 twenty per cent of the amount to be paid under section 38a-47, as

4826 amended by this act, among the domestic entities organized under
4827 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,
4828 in proportion to their respective shares of the total taxes and charges
4829 imposed under chapter 207 on such entities on business done in this
4830 state during the preceding calendar year, and (B) allocating eighty per
4831 cent of the amount to be paid under section 38a-47, as amended by this
4832 act, among all domestic insurance companies and domestic entities
4833 other than those organized under sections 38a-199 to 38a-209,
4834 inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their
4835 respective shares of the total taxes and charges imposed under chapter
4836 207 on such domestic insurance companies and domestic entities on
4837 business done in this state during the preceding calendar year,
4838 provided if there are no domestic entities organized under sections
4839 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the
4840 time of assessment, one hundred per cent of the amount to be paid
4841 under section 38a-47, as amended by this act, shall be allocated among
4842 such domestic insurance companies and domestic entities.

4843 (2) When the amount any such company or entity is assessed
4844 pursuant to this section exceeds twenty-five per cent of the actual
4845 expenditures of the Insurance Department, [and] the Office of the
4846 Healthcare Advocate and the Office of Health Strategy from the
4847 Insurance Fund, such excess amount shall not be paid by such
4848 company or entity but rather shall be assessed against and paid by all
4849 other such companies and entities in proportion to their respective
4850 shares of the total taxes and charges imposed under chapter 207 on
4851 business done in this state during the preceding calendar year, except
4852 that for purposes of any assessment made to fund payments to the
4853 Department of Public Health to purchase vaccines, such company or
4854 entity shall be responsible for its share of the costs, notwithstanding
4855 whether its assessment exceeds twenty-five per cent of the actual
4856 expenditures of the Insurance Department, [and] the Office of the
4857 Healthcare Advocate and the Office of Health Strategy from the
4858 Insurance Fund. The provisions of this subdivision shall not be
4859 applicable to any corporation which has converted to a domestic
4860 mutual insurance company pursuant to section 38a-155 upon the

4861 effective date of any public act which amends said section to modify or
4862 remove any restriction on the business such a company may engage in,
4863 for purposes of any assessment due from such company on and after
4864 such effective date.

4865 (d) For purposes of calculating the amount of payment under
4866 section 38a-47, as amended by this act, as well as the amount of the
4867 assessments under this section, the "total taxes imposed on all
4868 domestic insurance companies and other domestic entities under
4869 chapter 207" shall be based upon the amounts shown as payable to the
4870 state for the calendar year on the returns filed with the Commissioner
4871 of Revenue Services pursuant to chapter 207; with respect to
4872 calculating the amount of payment and assessment for local domestic
4873 insurance companies, the amount used shall be the taxes and charges
4874 imposed before any tax credits allowed as provided in subsection (a) of
4875 section 12-202.

4876 (e) On or before September thirtieth, annually, for each fiscal year
4877 ending prior to July 1, 1990, the Insurance Commissioner and the
4878 Healthcare Advocate, after receiving any objections to the proposed
4879 assessments and making such adjustments as in their opinion may be
4880 indicated, shall assess each such domestic insurance company or other
4881 domestic entity an amount equal to its proposed assessment as so
4882 adjusted. Each domestic insurance company or other domestic entity
4883 shall pay to the Insurance Commissioner on or before October thirty-
4884 first an amount equal to fifty per cent of its assessment adjusted to
4885 reflect any credit or amount due from the preceding fiscal year as
4886 determined by the commissioner under subsection (g) of this section.
4887 Each domestic insurance company or other domestic entity shall pay
4888 to the Insurance Commissioner on or before the following April
4889 thirtieth, the remaining fifty per cent of its assessment.

4890 (f) On or before September first, annually, for each fiscal year
4891 ending after July 1, 1990, the Insurance Commissioner and the
4892 Healthcare Advocate, after receiving any objections to the proposed
4893 assessments and making such adjustments as in their opinion may be

4894 indicated, shall assess each such domestic insurance company or other
4895 domestic entity an amount equal to its proposed assessment as so
4896 adjusted. Each domestic insurance company or other domestic entity
4897 shall pay to the Insurance Commissioner (1) on or before June 30, 1990,
4898 and on or before June thirtieth annually thereafter, an estimated
4899 payment against its assessment for the following year equal to twenty-
4900 five per cent of its assessment for the fiscal year ending such June
4901 thirtieth, (2) on or before September thirtieth, annually, twenty-five per
4902 cent of its assessment adjusted to reflect any credit or amount due
4903 from the preceding fiscal year as determined by the commissioner
4904 under subsection (g) of this section, and (3) on or before the following
4905 December thirty-first and March thirty-first, annually, each domestic
4906 insurance company or other domestic entity shall pay to the Insurance
4907 Commissioner the remaining fifty per cent of its proposed assessment
4908 to the department in two equal installments.

4909 (g) If the actual expenditures for the fall prevention program
4910 established in section 17a-303a are less than the amount allocated, the
4911 Commissioner of Social Services shall notify the Insurance
4912 Commissioner and the Healthcare Advocate. Immediately following
4913 the close of the fiscal year, the Insurance Commissioner and the
4914 Healthcare Advocate shall recalculate the proposed assessment for
4915 each domestic insurance company or other domestic entity in
4916 accordance with subsection (c) of this section using the actual
4917 expenditures made during the fiscal year by the Insurance
4918 Department, [and] the Office of the Healthcare Advocate [during that
4919 fiscal year] and the Office of Health Strategy from the Insurance Fund,
4920 the actual expenditures made on behalf of the department and the
4921 [office] offices from the Capital Equipment Purchase Fund pursuant to
4922 section 4a-9, not including such expenditures made on behalf of the
4923 Health Systems Planning Unit of the Office of Health Strategy, and the
4924 actual expenditures for the fall prevention program. On or before July
4925 thirty-first, the Insurance Commissioner and the Healthcare Advocate
4926 shall render to each such domestic insurance company and other
4927 domestic entity a statement showing the difference between their
4928 respective recalculated assessments and the amount they have

4929 previously paid. On or before August thirty-first, the Insurance
4930 Commissioner and the Healthcare Advocate, after receiving any
4931 objections to such statements, shall make such adjustments which in
4932 their opinion may be indicated, and shall render an adjusted
4933 assessment, if any, to the affected companies.

4934 (h) If any assessment is not paid when due, a penalty of twenty-five
4935 dollars shall be added thereto, and interest at the rate of six per cent
4936 per annum shall be paid thereafter on such assessment and penalty.

4937 (i) The commissioner shall deposit all payments made under this
4938 section with the State Treasurer. On and after June 6, 1991, the moneys
4939 so deposited shall be credited to the Insurance Fund established under
4940 section 38a-52a and shall be accounted for as expenses recovered from
4941 insurance companies.

4942 Sec. 120. Subsection (c) of section 1-84b of the general statutes is
4943 repealed and the following is substituted in lieu thereof (*Effective July*
4944 *1, 2018*):

4945 (c) The provisions of this subsection apply to present or former
4946 executive branch public officials or state employees who hold or
4947 formerly held positions which involve significant decision-making or
4948 supervisory responsibility and are designated as such by the Office of
4949 State Ethics in consultation with the agency concerned except that such
4950 provisions shall not apply to members or former members of the
4951 boards or commissions who serve ex officio, who are required by
4952 statute to represent the regulated industry or who are permitted by
4953 statute to have a past or present affiliation with the regulated industry.
4954 Designation of positions subject to the provisions of this subsection
4955 shall be by regulations adopted by the Citizen's Ethics Advisory Board
4956 in accordance with chapter 54. As used in this subsection, "agency"
4957 means the [Office of Health Care Access division within the
4958 Department of Public Health] Health Systems Planning Unit of the
4959 Office of Health Strategy, the Connecticut Siting Council, the
4960 Department of Banking, the Insurance Department, the Department of
4961 Emergency Services and Public Protection, the office within the

4962 Department of Consumer Protection that carries out the duties and
4963 responsibilities of sections 30-2 to 30-68m, inclusive, the Public Utilities
4964 Regulatory Authority, including the Office of Consumer Counsel, and
4965 the Department of Consumer Protection and the term "employment"
4966 means professional services or other services rendered as an employee
4967 or as an independent contractor.

4968 (1) No public official or state employee in an executive branch
4969 position designated by the Office of State Ethics shall negotiate for,
4970 seek or accept employment with any business subject to regulation by
4971 his agency.

4972 (2) No former public official or state employee who held such a
4973 position in the executive branch shall within one year after leaving an
4974 agency, accept employment with a business subject to regulation by
4975 that agency.

4976 (3) No business shall employ a present or former public official or
4977 state employee in violation of this subsection.

4978 Sec. 121. Section 3-123i of the general statutes is repealed and the
4979 following is substituted in lieu thereof (*Effective July 1, 2018*):

4980 For the fiscal year ending June 30, 2014, and for each fiscal year
4981 thereafter, the Comptroller shall fund the fringe benefit cost
4982 differential between the average rate for fringe benefits for employees
4983 of private hospitals in the state and the fringe benefit rate for
4984 employees of The University of Connecticut Health Center from the
4985 resources appropriated for State Comptroller-Fringe Benefits in an
4986 amount not to exceed \$13,500,000. For purposes of this section, the
4987 "fringe benefit cost differential" means the difference between the state
4988 fringe benefit rate calculated on The University of Connecticut Health
4989 Center payroll and the average member fringe benefit rate of all
4990 Connecticut acute care hospitals as contained in the annual reports
4991 submitted to the [Office of Health Care Access] Health Systems
4992 Planning Unit of the Office of Health Strategy pursuant to section 19a-
4993 644, as amended by this act.

4994 Sec. 122. Subsection (b) of section 4-101a of the general statutes is
4995 repealed and the following is substituted in lieu thereof (*Effective July*
4996 *1, 2018*):

4997 (b) Grants, technical assistance or consultation services, or any
4998 combination thereof, provided under this section may be made to
4999 assist a nongovernmental acute care general hospital to develop and
5000 implement a plan to achieve financial stability and assure the delivery
5001 of appropriate health care services in the service area of such hospital,
5002 or to assist a nongovernmental acute care general hospital in
5003 determining strategies, goals and plans to ensure its financial viability
5004 or stability. Any such hospital seeking such grants, technical assistance
5005 or consultation services shall prepare and submit to the Office of Policy
5006 and Management and the [Office of Health Care Access division of the
5007 Department of Public Health] Health Systems Planning Unit of the
5008 Office of Health Strategy a plan that includes at least the following: (1)
5009 A statement of the hospital's current projections of its finances for the
5010 current and the next three fiscal years; (2) identification of the major
5011 financial issues which effect the financial stability of the hospital; (3)
5012 the steps proposed to study or improve the financial status of the
5013 hospital and eliminate ongoing operating losses; (4) plans to study or
5014 change the mix of services provided by the hospital, which may
5015 include transition to an alternative licensure category; and (5) other
5016 related elements as determined by the Office of Policy and
5017 Management. Such plan shall clearly identify the amount, value or
5018 type of the grant, technical assistance or consultation services, or
5019 combination thereof, requested. Any grants, technical assistance or
5020 consultation services, or any combination thereof, provided under this
5021 section shall be determined by the Secretary of the Office of Policy and
5022 Management not to jeopardize the federal matching payments under
5023 the medical assistance program and the emergency assistance to
5024 families program as determined by the [Office of Health Care Access
5025 division of the Department of Public Health] Health Systems Planning
5026 Unit of the Office of Health Strategy or the Department of Social
5027 Services in consultation with the Office of Policy and Management.

5028 Sec. 123. Subsection (c) of section 17b-337 of the 2018 supplement to
5029 the general statutes is repealed and the following is substituted in lieu
5030 thereof (*Effective July 1, 2018*):

5031 (c) The Long-Term Care Planning Committee shall consist of: (1)
5032 The chairpersons and ranking members of the joint standing
5033 committees of the General Assembly having cognizance of matters
5034 relating to human services, public health, elderly services and long-
5035 term care; (2) the Commissioner of Social Services, or the
5036 commissioner's designee; (3) one member of the Office of Policy and
5037 Management appointed by the Secretary of the Office of Policy and
5038 Management; (4) ~~[two members]~~ one member from the Department of
5039 Public Health appointed by the Commissioner of Public Health; ~~[, one~~
5040 ~~of whom is from the Office of Health Care Access division of the~~
5041 ~~department;]~~ (5) one member from the Department of Housing
5042 appointed by the Commissioner of Housing; (6) one member from the
5043 Department of Developmental Services appointed by the
5044 Commissioner of Developmental Services; (7) one member from the
5045 Department of Mental Health and Addiction Services appointed by the
5046 Commissioner of Mental Health and Addiction Services; (8) one
5047 member from the Department of Transportation appointed by the
5048 Commissioner of Transportation; ~~[and]~~ (9) one member from the
5049 Department of Children and Families appointed by the Commissioner
5050 of Children and Families; and (10) one member from the Health
5051 Systems Planning Unit of the Office of Health Strategy appointed by
5052 the executive director of the Office of Health Strategy. The committee
5053 shall convene no later than ninety days after June 4, 1998. Any vacancy
5054 shall be filled by the appointing authority. The chairperson shall be
5055 elected from among the members of the committee. The committee
5056 shall seek the advice and participation of any person, organization or
5057 state or federal agency it deems necessary to carry out the provisions
5058 of this section.

5059 Sec. 124. Subsection (g) of section 17b-352 of the 2018 supplement to
5060 the general statutes is repealed and the following is substituted in lieu
5061 thereof (*Effective July 1, 2018*):

5062 (g) The Commissioner of Social Services shall adopt regulations, in
5063 accordance with chapter 54, to implement the provisions of this
5064 section. [The commissioner shall implement the standards and
5065 procedures of the Office of Health Care Access division of the
5066 Department of Public Health concerning certificates of need
5067 established pursuant to section 19a-643, as appropriate for the
5068 purposes of this section, until the time final regulations are adopted in
5069 accordance with said chapter 54.]

5070 Sec. 125. Subsection (e) of section 17b-353 of the 2018 supplement to
5071 the general statutes is repealed and the following is substituted in lieu
5072 thereof (*Effective July 1, 2018*):

5073 (e) The Commissioner of Social Services shall adopt regulations, in
5074 accordance with chapter 54, to implement the provisions of this
5075 section. [The commissioner shall implement the standards and
5076 procedures of the Office of Health Care Access division of the
5077 Department of Public Health concerning certificates of need
5078 established pursuant to section 19a-643, as appropriate for the
5079 purposes of this section, until the time final regulations are adopted in
5080 accordance with said chapter 54.]

5081 Sec. 126. Subsection (f) of section 17b-354 of the 2018 supplement to
5082 the general statutes is repealed and the following is substituted in lieu
5083 thereof (*Effective July 1, 2018*):

5084 (f) The Commissioner of Social Services may adopt regulations, in
5085 accordance with chapter 54, to implement the provisions of this
5086 section. [The commissioner shall implement the standards and
5087 procedures of the Office of Health Care Access division of the
5088 Department of Public Health concerning certificates of need
5089 established pursuant to section 19a-643, as appropriate for the
5090 purposes of this section, until the time final regulations are adopted in
5091 accordance with said chapter 54.]

5092 Sec. 127. Section 17b-356 of the general statutes is repealed and the
5093 following is substituted in lieu thereof (*Effective July 1, 2018*):

5094 Any health care facility or institution, as defined in subsection (a) of
5095 section 19a-490, as amended by this act, except a nursing home, rest
5096 home, residential care home or residential facility for persons with
5097 intellectual disability licensed pursuant to section 17a-227 and certified
5098 to participate in the Title XIX Medicaid program as an intermediate
5099 care facility for individuals with intellectual disabilities, proposing to
5100 expand its services by adding nursing home beds shall obtain the
5101 approval of the Commissioner of Social Services in accordance with
5102 the procedures established pursuant to sections 17b-352, as amended
5103 by this act, 17b-353, as amended by this act, and 17b-354, as amended
5104 by this act, for a facility, as defined in section 17b-352, as amended by
5105 this act, prior to obtaining the approval of the [Office of Health Care
5106 Access division of the Department of Public Health] Health Systems
5107 Planning Unit of the Office of Health Strategy pursuant to section 19a-
5108 639, as amended by this act.

5109 Sec. 128. Subsection (b) of section 19a-7 of the general statutes is
5110 repealed and the following is substituted in lieu thereof (*Effective July*
5111 *1, 2018*):

5112 (b) For the purposes of establishing a state health plan as required
5113 by subsection (a) of this section and consistent with state and federal
5114 law on patient records, the department is entitled to access hospital
5115 discharge data, emergency room and ambulatory surgery encounter
5116 data, data on home health care agency client encounters and services,
5117 data from community health centers on client encounters and services
5118 and all data collected or compiled by the [Office of Health Care Access
5119 division of the Department of Public Health] Health Systems Planning
5120 Unit of the Office of Health Strategy pursuant to section 19a-613, as
5121 amended by this act.

5122 Sec. 129. Subsection (a) of section 19a-507 of the general statutes is
5123 repealed and the following is substituted in lieu thereof (*Effective July*
5124 *1, 2018*):

5125 (a) Notwithstanding the provisions of chapter 368z, New Horizons,
5126 Inc., a nonprofit, nonsectarian organization, or a subsidiary

5127 organization controlled by New Horizons, Inc., is authorized to
5128 construct and operate an independent living facility for severely
5129 physically disabled adults, in the town of Farmington, provided such
5130 facility shall be constructed in accordance with applicable building
5131 codes. The Farmington Housing Authority, or any issuer acting on
5132 behalf of said authority, subject to the provisions of this section, may
5133 issue tax-exempt revenue bonds on a competitive or negotiated basis
5134 for the purpose of providing construction and permanent mortgage
5135 financing for the facility in accordance with Section 103 of the Internal
5136 Revenue Code. Prior to the issuance of such bonds, plans for the
5137 construction of the facility shall be submitted to and approved by the
5138 [Office of Health Care Access] Health Systems Planning Unit of the
5139 Office of Health Strategy. The [office] unit shall approve or disapprove
5140 such plans within thirty days of receipt thereof. If the plans are
5141 disapproved they may be resubmitted. Failure of the [office] unit to act
5142 on the plans within such thirty-day period shall be deemed approval
5143 thereof. The payments to residents of the facility who are eligible for
5144 assistance under the state supplement program for room and board
5145 and necessary services, shall be determined annually to be effective
5146 July first of each year. Such payments shall be determined on a basis of
5147 a reasonable payment for necessary services, which basis shall take
5148 into account as a factor the costs of providing those services and such
5149 other factors as the commissioner deems reasonable, including
5150 anticipated fluctuations in the cost of providing services. Such
5151 payments shall be calculated in accordance with the manner in which
5152 rates are calculated pursuant to subsection (h) of section 17b-340 and
5153 the cost-related reimbursement system pursuant to said section except
5154 that efficiency incentives shall not be granted. The commissioner may
5155 adjust such rates to account for the availability of personal care
5156 services for residents under the Medicaid program. The commissioner
5157 shall, upon submission of a request, allow actual debt service,
5158 comprised of principal and interest, in excess of property costs allowed
5159 pursuant to section 17-313b-5 of the regulations of Connecticut state
5160 agencies, provided such debt service terms and amounts are
5161 reasonable in relation to the useful life and the base value of the

5162 property. The cost basis for such payment shall be subject to audit, and
5163 a recomputation of the rate shall be made based upon such audit. The
5164 facility shall report on a fiscal year ending on the thirtieth day of
5165 September on forms provided by the commissioner. The required
5166 report shall be received by the commissioner no later than December
5167 thirty-first of each year. The Department of Social Services may use its
5168 existing utilization review procedures to monitor utilization of the
5169 facility. If the facility is aggrieved by any decision of the commissioner,
5170 the facility may, within ten days, after written notice thereof from the
5171 commissioner, obtain by written request to the commissioner, a
5172 hearing on all items of aggrievement. If the facility is aggrieved by the
5173 decision of the commissioner after such hearing, the facility may
5174 appeal to the Superior Court in accordance with the provisions of
5175 section 4-183.

5176 Sec. 130. Subsection (c) of section 12-263q of the 2018 supplement to
5177 the general statutes is repealed and the following is substituted in lieu
5178 thereof (*Effective July 1, 2018*):

5179 (c) Prior to January 1, 2018, and every three years thereafter, the
5180 Commissioner of Social Services shall seek approval from the Centers
5181 for Medicare and Medicaid Services to exempt financially distressed
5182 hospitals from the net revenue tax imposed on outpatient hospital
5183 services. Any such hospital for which the Centers for Medicare and
5184 Medicaid Services grants an exemption shall be exempt from the net
5185 revenue tax imposed on outpatient hospital services under subsection
5186 (a) of this section. Any hospital for which the Centers for Medicare and
5187 Medicaid Services denies an exemption shall be required to pay the net
5188 revenue tax imposed on outpatient hospital services under subsection
5189 (a) of this section. For purposes of this subsection, "financially
5190 distressed hospital" means a hospital that has experienced over a five-
5191 year period an average net loss of more than five per cent of aggregate
5192 revenue. A hospital has an average net loss of more than five per cent
5193 of aggregate revenue if such a loss is reflected in the five most recent
5194 years of financial reporting that have been made available by the
5195 [Office of Health Care Access] Health Systems Planning Unit of the

5196 Office of Health Strategy for such hospital in accordance with section
5197 19a-670, as amended by this act, as of the effective date of the request
5198 for approval which effective date shall be July first of the year in which
5199 the request is made.

5200 Sec. 131. Subsection (b) of section 13 of public act 17-4 of the June
5201 special session is repealed and the following is substituted in lieu
5202 thereof (*Effective July 1, 2018*):

5203 (b) The commissioner may impose such conditions as the
5204 commissioner determines to be necessary in making any advance in
5205 accordance with this section, including, but not limited to, financial
5206 reporting, schedule of recoupment of advance payments and
5207 adjustments to any future payments to such hospital. For purposes of
5208 this section, "distressed hospital" means a short-term general acute care
5209 hospital licensed by the Department of Public Health that (1) the
5210 Commissioner of Social Services determines is financially distressed in
5211 accordance with financial criteria selected or developed by the
5212 commissioner, and (2) is independent and is not affiliated with any
5213 other hospital or hospital-based system that includes two or more
5214 hospitals, as documented through the certificate of need process
5215 administered by the [Department of Public Health, Office of Health
5216 Care Access] Health Systems Planning Unit of the Office of Health
5217 Strategy.

5218 Sec. 132. Subsection (b) of section 10a-109gg of the general statutes is
5219 repealed and the following is substituted in lieu thereof (*Effective July*
5220 *1, 2018*):

5221 (b) The proceeds of the sale of the bond issuance described in
5222 subsection (a) of this section shall be used by the Office of Policy and
5223 Management, in consultation with the chairperson of the Board of
5224 Trustees of the university, for the purpose of the UConn health
5225 network initiatives in the following manner: (1) Five million dollars of
5226 such proceeds shall be used by Hartford Hospital to develop a
5227 simulation and conference center on the Hartford Hospital campus to
5228 be run exclusively by Hartford Hospital, (2) five million dollars of such

5229 proceeds shall be used to fulfill the initiative for a primary care
5230 institute on the Saint Francis Hospital and Medical Center campus, (3)
5231 five million dollars of such proceeds shall be used to fulfill the
5232 initiatives for a comprehensive cancer center and The University of
5233 Connecticut-sponsored health disparities institute; (4) five million
5234 dollars of such proceeds shall be used to fulfill the initiatives for the
5235 planning, design, land acquisition, development and construction of
5236 (A) a cancer treatment center to be constructed by, or in partnership
5237 with, The Hospital of Central Connecticut, provided such cancer
5238 treatment center is located entirely within the legal boundaries of the
5239 city of New Britain, (B) renovations and upgrades to the oncology unit
5240 at The Hospital of Central Connecticut, and (C) if certificate of need
5241 approval is received, [pursuant to the provisions of subsection (b) of
5242 section 10a-109ii,] a Permanent Regional Phase One Clinical Trials Unit
5243 located at The Hospital of Central Connecticut in New Britain; and (5)
5244 two million dollars of such proceeds shall be used to fulfill the
5245 initiatives for patient room renovations at Bristol Hospital. In the event
5246 that the cancer treatment center authorized pursuant to subdivision (4)
5247 of this subsection is built in whole or in part outside the legal
5248 boundaries of the city of New Britain, The Hospital of Central
5249 Connecticut shall repay the entire amount of the proceeds used to
5250 fulfill the initiatives for the planning, design, development and
5251 construction of such center.

5252 Sec. 133. Subsection (d) of section 1-84 of the 2018 supplement to the
5253 general statutes is repealed and the following is substituted in lieu
5254 thereof (*Effective July 1, 2018*):

5255 (d) No public official or state employee or employee of such public
5256 official or state employee shall agree to accept, or be a member or
5257 employee of a partnership, association, professional corporation or
5258 sole proprietorship which partnership, association, professional
5259 corporation or sole proprietorship agrees to accept any employment,
5260 fee or other thing of value, or portion thereof, for appearing, agreeing
5261 to appear, or taking any other action on behalf of another person
5262 before the Department of Banking, the Office of the Claims

5263 Commissioner, the [Office of Health Care Access division within the
5264 Department of Public Health] Health Systems Planning Unit of the
5265 Office of Health Strategy, the Insurance Department, the Department
5266 of Consumer Protection, the Department of Motor Vehicles, the State
5267 Insurance and Risk Management Board, the Department of Energy and
5268 Environmental Protection, the Public Utilities Regulatory Authority,
5269 the Connecticut Siting Council or the Connecticut Real Estate
5270 Commission; provided this shall not prohibit any such person from
5271 making inquiry for information on behalf of another before any of said
5272 commissions or commissioners if no fee or reward is given or
5273 promised in consequence thereof. For the purpose of this subsection,
5274 partnerships, associations, professional corporations or sole
5275 proprietorships refer only to such partnerships, associations,
5276 professional corporations or sole proprietorships which have been
5277 formed to carry on the business or profession directly relating to the
5278 employment, appearing, agreeing to appear or taking of action
5279 provided for in this subsection. Nothing in this subsection shall
5280 prohibit any employment, appearing, agreeing to appear or taking
5281 action before any municipal board, commission or council. Nothing in
5282 this subsection shall be construed as applying (1) to the actions of any
5283 teaching or research professional employee of a public institution of
5284 higher education if such actions are not in violation of any other
5285 provision of this chapter, (2) to the actions of any other professional
5286 employee of a public institution of higher education if such actions are
5287 not compensated and are not in violation of any other provision of this
5288 chapter, (3) to any member of a board or commission who receives no
5289 compensation other than per diem payments or reimbursement for
5290 actual or necessary expenses, or both, incurred in the performance of
5291 the member's duties, or (4) to any member or director of a quasi-public
5292 agency. Notwithstanding the provisions of this subsection to the
5293 contrary, a legislator, an officer of the General Assembly or part-time
5294 legislative employee may be or become a member or employee of a
5295 firm, partnership, association or professional corporation which
5296 represents clients for compensation before agencies listed in this
5297 subsection, provided the legislator, officer of the General Assembly or

5298 part-time legislative employee shall take no part in any matter
 5299 involving the agency listed in this subsection and shall not receive
 5300 compensation from any such matter. Receipt of a previously
 5301 established salary, not based on the current or anticipated business of
 5302 the firm, partnership, association or professional corporation involving
 5303 the agencies listed in this subsection, shall be permitted.

5304 Sec. 134. Section 249 of public act 17-2 of the June special session is
 5305 repealed. (*Effective from passage*)

5306 Sec. 135. Sections 17a-451b, 17a-560a, 17a-576 and 20-185n of the
 5307 general statutes are repealed. (*Effective from passage*)

5308 Sec. 136. Sections 10a-109ii, 17b-234, 17b-235, 19a-617b, 19a-637, 19a-
 5309 755 and 38a-558 of the general statutes are repealed. (*Effective July 1,*
 5310 *2018*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2018</i>	4-28f
Sec. 2	<i>October 1, 2018</i>	19a-55(a)
Sec. 3	<i>July 1, 2018</i>	New section
Sec. 4	<i>from passage</i>	19a-490(a)
Sec. 5	<i>from passage</i>	1-210(b)(18)
Sec. 6	<i>from passage</i>	1-210(c)
Sec. 7	<i>from passage</i>	5-145a
Sec. 8	<i>from passage</i>	5-173
Sec. 9	<i>from passage</i>	5-192f(d)
Sec. 10	<i>from passage</i>	17a-450(b)
Sec. 11	<i>from passage</i>	17a-450(c)(3)
Sec. 12	<i>from passage</i>	17a-450a(a)
Sec. 13	<i>from passage</i>	17a-458(c)
Sec. 14	<i>from passage</i>	17a-470
Sec. 15	<i>from passage</i>	17a-471a
Sec. 16	<i>from passage</i>	17a-472
Sec. 17	<i>from passage</i>	17a-495
Sec. 18	<i>from passage</i>	17a-496
Sec. 19	<i>from passage</i>	17a-497(b)
Sec. 20	<i>from passage</i>	17a-498(g)

Sec. 21	<i>from passage</i>	17a-499
Sec. 22	<i>from passage</i>	17a-500(a)
Sec. 23	<i>from passage</i>	17a-501
Sec. 24	<i>from passage</i>	17a-504
Sec. 25	<i>from passage</i>	17a-505
Sec. 26	<i>from passage</i>	17a-517
Sec. 27	<i>from passage</i>	17a-519
Sec. 28	<i>from passage</i>	17a-521
Sec. 29	<i>from passage</i>	17a-525
Sec. 30	<i>from passage</i>	17a-528(a)
Sec. 31	<i>from passage</i>	17a-548(a)
Sec. 32	<i>from passage</i>	17a-560
Sec. 33	<i>from passage</i>	17a-561
Sec. 34	<i>from passage</i>	17a-562
Sec. 35	<i>from passage</i>	17a-564
Sec. 36	<i>from passage</i>	17a-565
Sec. 37	<i>from passage</i>	17a-566
Sec. 38	<i>from passage</i>	17a-567
Sec. 39	<i>from passage</i>	17a-568
Sec. 40	<i>from passage</i>	17a-569
Sec. 41	<i>from passage</i>	17a-570
Sec. 42	<i>from passage</i>	17a-572
Sec. 43	<i>from passage</i>	17a-573
Sec. 44	<i>from passage</i>	17a-574
Sec. 45	<i>from passage</i>	17a-575
Sec. 46	<i>from passage</i>	45a-656(d)
Sec. 47	<i>July 1, 2018</i>	45a-656(d)
Sec. 48	<i>from passage</i>	45a-677(e)
Sec. 49	<i>from passage</i>	18-101f
Sec. 50	<i>from passage</i>	46a-152(a)
Sec. 51	<i>from passage</i>	12-19a(a)
Sec. 52	<i>from passage</i>	12-18b(b)(1)(D)
Sec. 53	<i>October 1, 2018</i>	New section
Sec. 54	<i>October 1, 2018</i>	New section
Sec. 55	<i>July 1, 2018</i>	19a-754a
Sec. 56	<i>July 1, 2018</i>	4-5
Sec. 57	<i>July 1, 2019</i>	4-5
Sec. 58	<i>July 1, 2018</i>	19a-755a
Sec. 59	<i>July 1, 2018</i>	19a-755b
Sec. 60	<i>July 1, 2018</i>	38a-477e(a)
Sec. 61	<i>July 1, 2018</i>	17b-59a

Sec. 62	July 1, 2018	17b-59c
Sec. 63	July 1, 2018	17b-59d(d)(1)
Sec. 64	July 1, 2018	17b-59d(f)
Sec. 65	July 1, 2018	17b-59f
Sec. 66	July 1, 2018	17b-59g
Sec. 67	July 1, 2018	2-124a(b)
Sec. 68	July 1, 2018	19a-612
Sec. 69	July 1, 2018	19a-612d
Sec. 70	July 1, 2018	19a-613
Sec. 71	July 1, 2018	19a-614
Sec. 72	July 1, 2018	19a-630
Sec. 73	July 1, 2018	19a-631(b)
Sec. 74	July 1, 2018	19a-632
Sec. 75	July 1, 2018	19a-632a(b)
Sec. 76	July 1, 2018	19a-632a(f)
Sec. 77	July 1, 2018	19a-633
Sec. 78	July 1, 2018	19a-634
Sec. 79	July 1, 2018	19a-638
Sec. 80	July 1, 2018	19a-639
Sec. 81	July 1, 2018	19a-639a
Sec. 82	July 1, 2018	19a-639b
Sec. 83	July 1, 2018	19a-639c
Sec. 84	July 1, 2018	19a-639e
Sec. 85	July 1, 2018	19a-639f
Sec. 86	July 1, 2018	19a-641
Sec. 87	July 1, 2018	19a-642
Sec. 88	July 1, 2018	19a-643
Sec. 89	July 1, 2018	19a-644
Sec. 90	July 1, 2018	19a-645
Sec. 91	July 1, 2018	19a-646
Sec. 92	July 1, 2018	19a-649
Sec. 93	July 1, 2018	19a-653
Sec. 94	July 1, 2018	19a-654
Sec. 95	July 1, 2018	19a-659
Sec. 96	July 1, 2018	19a-670
Sec. 97	July 1, 2018	19a-673(a)(1)
Sec. 98	July 1, 2018	19a-673a
Sec. 99	July 1, 2018	19a-673c
Sec. 100	July 1, 2018	19a-676
Sec. 101	July 1, 2018	19a-681
Sec. 102	July 1, 2018	19a-486

Sec. 103	July 1, 2018	19a-486a
Sec. 104	July 1, 2018	19a-486b
Sec. 105	July 1, 2018	19a-486d
Sec. 106	July 1, 2018	19a-486e
Sec. 107	July 1, 2018	19a-486f
Sec. 108	July 1, 2018	19a-486g
Sec. 109	July 1, 2018	19a-486h
Sec. 110	July 1, 2018	19a-486i(d) to (i)
Sec. 111	July 1, 2018	19a-508c(j) to (m)
Sec. 112	July 1, 2018	19a-509b(c) to (f)
Sec. 113	July 1, 2018	33-182bb(e) to (g)
Sec. 114	July 1, 2018	19a-493b(b) and (c)
Sec. 115	July 1, 2018	19a-6q
Sec. 116	July 1, 2018	19a-725
Sec. 117	July 1, 2018	20-195sss
Sec. 118	July 1, 2018	38a-47
Sec. 119	July 1, 2018	38a-48
Sec. 120	July 1, 2018	1-84b(c)
Sec. 121	July 1, 2018	3-123i
Sec. 122	July 1, 2018	4-101a(b)
Sec. 123	July 1, 2018	17b-337(c)
Sec. 124	July 1, 2018	17b-352(g)
Sec. 125	July 1, 2018	17b-353(e)
Sec. 126	July 1, 2018	17b-354(f)
Sec. 127	July 1, 2018	17b-356
Sec. 128	July 1, 2018	19a-7(b)
Sec. 129	July 1, 2018	19a-507(a)
Sec. 130	July 1, 2018	12-263q(c)
Sec. 131	July 1, 2018	PA 17-4 of the June Sp. Sess., Sec. 13(b)
Sec. 132	July 1, 2018	10a-109gg(b)
Sec. 133	July 1, 2018	1-84(d)
Sec. 134	<i>from passage</i>	Repealer section
Sec. 135	<i>from passage</i>	Repealer section
Sec. 136	July 1, 2018	Repealer section

Statement of Legislative Commissioners:

In Section 17, Subsecs. (a), (c) and (d) were added for purposes of incorporating a conforming change into Subsec. (d). In Section 36(a), in the first sentence, "hospital" was changed to "Whiting Forensic Hospital", for clarity. In Section 53(e), ", or to the person or persons

designated by the commissioner to receive such reports," was added after "Services" for consistency. In Section 54(a), in the first sentence, "commissioner" was changed to "Commissioner of Mental Health and Addiction Services" for clarity; and in Section 54(e)(2) ", neglect, or exploitation" was deleted for consistency.

PH

Joint Favorable Subst.

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 19 \$	FY 20 \$
Public Health, Dept.	GF - Cost	141,750	141,750
State Comptroller - Fringe Benefits ¹	GF - Cost	17,711	17,711
Mental Health & Addiction Serv., Dept.	GF - Cost	1 million	3.1 million
State Comptroller - Fringe Benefits	GF - Cost	363,300	1.1 million
Resources of the General Fund	GF - Potential Revenue Gain	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill does the following: (1) makes conforming statutory changes to Executive Order No. 63, which designated the Whiting Forensic Division of Connecticut Valley Hospital (CVH) as a separate hospital entity effective 12/31/17, (2) requires any disorder included on the federal Recommended Uniform Screening Panel (RUSP) to be included in Connecticut's Newborn Screening Program, and (3) creates a new category of mandated reporter for abuse of patients at certain Department of Mental Health and Addiction Services (DMHAS)-operated facilities. The fiscal impacts of these three items are discussed below. Other provisions of the bill are not anticipated to have a fiscal impact.

(1) The establishment of Whiting Forensic Hospital results in a state cost of approximately \$1.4 million in FY 19. DMHAS must support

¹The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 36.33% of payroll in FY 19 and FY 20.

additional staff at the new hospital, as well as CVH, to ensure that these institutions are separate and distinct entities. Based on an initial evaluation, 30 DMHAS employees (including Behavioral Health Clinical Managers, Advanced Nurse Practitioners, and pharmacy staff) will be needed at an anticipated cost of approximately \$1 million in FY 19 and \$3.1 million in FY 20 (annualized), with associated fringe benefit costs of \$363,300 in FY 19 and \$1.1 million in FY 20.

(2) The RUSP provision results in a state cost of approximately \$160,000 annually. This includes support for a Department of Public Health (DPH) Health Program Assistant I (approximately \$49,000 annually), associated fringe benefits (approximately \$18,000 annually), and other expenses for testing (approximately \$93,000 annually) to expand the Connecticut Newborn Screening Program to include Pompe Disease and Mucopolysaccharidosis Type I.

(3) A new category of mandated reporter for abuse of patients at certain DMHAS-operated facilities could result in a General Fund revenue gain to the extent fines are imposed on mandated reporters that fail to comply with reporting requirements. A mandated reporter that fails to report abuse to DMHAS within 72-hours can be fined up to \$500. If the failure was intentional, the reporter could be fined up to \$500 for the first offense and up to \$2,000 for any subsequent offense.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, and the extent to which fines are imposed on mandated reporters.

OLR Bill Analysis**sSB 16****AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS REGARDING PUBLIC HEALTH.**

TABLE OF CONTENTS:

[§ 1 — TOBACCO AND HEALTH TRUST FUND BOARD](#)

Requires the Tobacco and Health Trust Fund Board to report to the legislature only following a fiscal year when it receives a deposit from the Tobacco Settlement Fund, instead of annually; eliminates the requirement that the board meet at least biannually

[§ 2 — DPH NEWBORN SCREENING PROGRAM](#)

Expands the Department of Public Health's (DPH) Newborn Screening Program to include screening for any disorder recommended on the U.S. Department of Health and Human Services' uniform newborn screening panel, if the Office of Policy and Management Secretary approves it

[§§ 3 & 134 — REDUCTIONS FOR MUNICIPAL AND DISTRICT
HEALTH DEPARTMENTS](#)

Requires DPH to reduce payments to municipal and district health departments proportionally if the total amount of these payments in a fiscal year exceeds the appropriated amount; repeals a related provision in PA 17-2, JSS

[§§ 4-52 & 135 — WHITING FORENSIC HOSPITAL](#)

Subjects Whiting Forensic Hospital to DPH licensure and regulation, which it is currently exempt from; makes various minor, technical, and conforming changes to reflect the hospital's separation from Connecticut Valley Hospital pursuant to 2017 Executive Order 63

[§ 53 — MANDATORY REPORTING OF SUSPECTED PATIENT ABUSE](#)

Establishes mandatory reporting of suspected patient abuse at DMHAS-operated behavioral health facilities by employees who provide direct patient care and licensed health care providers who are facility employees, contractors, or consultants; establishes related reporting requirements and penalties

§ 54 — PATIENT ABUSE INVESTIGATIONS

Requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients and establishes related requirements, such as disclosure of and access to patient abuse reports and investigations

§§ 55-136 — OFFICE OF HEALTH STRATEGY

Effectuates the establishment of the Office of Health Strategy (OHS) pursuant to PA 17-2, JSS by making various minor, technical, and conforming changes; transfers administration of the Office of Health Care Access from DPH to OHS and renames the office the Health Systems Planning Unit

§§ 135 & 136 — REPEALERS

Repeals obsolete provisions in various DPH- and DMHAS-related statutes

BACKGROUND

The bill also makes various minor, technical, and conforming changes.

EFFECTIVE DATE: July 1, 2018, unless otherwise noted below.

§ 1 — TOBACCO AND HEALTH TRUST FUND BOARD

Requires the Tobacco and Health Trust Fund Board to report to the legislature only following a fiscal year when it receives a deposit from the Tobacco Settlement Fund, instead of annually; eliminates the requirement that the board meet at least biannually

Current law requires the Tobacco and Health Trust Fund Board to report (1) its activities and accomplishments to the Appropriations and Public Health committees by January 1st annually and (2) all disbursements and expenditures and an evaluation of fund recipients' performance and impact to the legislature by February 1st annually. The bill instead requires the board to submit these reports only following a fiscal year in which the trust fund receives a deposit from the Tobacco Settlement Fund.

The bill also eliminates current law's requirement that the 17-member board meet at least biannually.

EFFECTIVE DATE: October 1, 2018

§ 2 — DPH NEWBORN SCREENING PROGRAM

Expands the Department of Public Health's (DPH) Newborn Screening Program to include screening for any disorder recommended on the U.S. Department of Health and Human Services' uniform newborn screening panel, if the Office of Policy and Management Secretary approves it

By law, the Department of Public Health (DPH) administers a newborn screening program that requires all health care institutions caring for newborn infants to test them for certain genetic and metabolic disorders, including (1) amino and organic acid disorders and (2) fatty acid oxidation disorders. The bill requires newborns to be screened for any other disorder recommended on the federal Department of Health and Human Services' uniform newborn screening panel, if the Office of Policy and Management Secretary approves it.

By law, in addition to the initial screening test, the program directs parents of identified infants to appropriate treatment.

Separate from the newborn screening program, the law also requires these institutions to test infants for such things as (1) critical congenital heart disease, (2) cystic fibrosis, and (3) under certain conditions, cytomegalovirus (CGS § 19a-55).

EFFECTIVE DATE: October 1, 2018

§§ 3 & 134 — REDUCTIONS FOR MUNICIPAL AND DISTRICT HEALTH DEPARTMENTS

Requires DPH to reduce payments to municipal and district health departments proportionally if the total amount of these payments in a fiscal year exceeds the appropriated amount; repeals a related provision in PA 17-2, JSS

The bill repeals a provision in PA 17-2, JSS (§ 249) that requires the DPH commissioner to reduce, on a pro rata basis, payments to municipal and district health departments by a total of \$504,218 for FY 19. It instead requires DPH to reduce payments to municipal and district health departments proportionately if the total amount of these payments in a fiscal year exceeds the appropriated amount.

To receive state funding, existing law requires that, among other things, (1) municipalities have a full-time health department and a

population of at least 50,000 and (2) health districts have a total population of at least 50,000 or serve three or more municipalities, regardless of their combined total population.

EFFECTIVE DATE: July 1, 2018, except that the provision repealing PA 17-2, JSS (§ 249) takes effect upon passage.

§§ 4-52 & 135 — WHITING FORENSIC HOSPITAL

Subjects Whiting Forensic Hospital to DPH licensure and regulation, which it is currently exempt from; makes various minor, technical, and conforming changes to reflect the hospital's separation from Connecticut Valley Hospital pursuant to 2017 Executive Order 63

In December 2017, the governor issued Executive Order 63, which designated Whiting Forensic Hospital as an independent division within the Department of Mental Health and Addiction Services (DMHAS), instead of a division of Connecticut Valley Hospital (CVH). The bill effectuates the executive order by making various minor, technical, and conforming changes to reflect the hospital's separation from CVH.

As under current law, Whiting Forensic Hospital remains under DMHAS administrative control and supervision. But the bill subjects it to DPH regulation by adding Whiting Forensic Hospital to the statutory definition of health care "institution." In doing so, the bill subjects Whiting Forensic Hospital to DPH hospital licensure, inspection, and complaint investigation requirements. Under current law, state psychiatric hospitals are not licensed and are exempt from DPH regulation.

By law, Whiting Forensic Hospital, under maximum security conditions, generally provides care for patients with psychiatric issues, some of whom have been convicted of serious offenses or were found incompetent to stand trial.

EFFECTIVE DATE: Upon passage, except for a technical change (§ 47) which takes effect July 1, 2018.

DMHAS Control (§ 16)

The bill requires the director of Whiting Forensic Hospital to report to the DMHAS commissioner, instead of CVH's director of forensic services.

Searches of Patients' Personal Belongings (§ 31)

Current law prohibits Whiting Forensic Hospital patients from being present when their personal belongings are searched. The bill specifies that this prohibition applies only to patients in the hospital's maximum security service, and not those in other units.

Advisory Board (§ 36)

The bill requires the Whiting Forensic Hospital's nine-member advisory board to develop policies and set standards related to hospital patients. The policies and standards must ensure that no discharge of a patient admitted to the hospital under Superior Court commitment or client transfer from the Department of Correction occurs without complying with applicable state laws.

§ 53 — MANDATORY REPORTING OF SUSPECTED PATIENT ABUSE

Establishes mandatory reporting of suspected patient abuse at DMHAS-operated behavioral health facilities by employees who provide direct patient care and licensed health care providers who are facility employees, contractors, or consultants; establishes related reporting requirements and penalties

The bill requires a person to report suspected abuse of a patient receiving services from a DMHAS-operated facility for mental health or substance abuse disorders (i.e., "behavioral health facility") if the person is a mandated reporter who, in the ordinary course of his or her employment, reasonably suspects a patient has:

1. been abused or is in a condition resulting from abuse or
2. had an injury that is at variance with the history given of the injury.

Under the bill, "abuse" means (1) the willful infliction of physical pain, injury, or mental anguish, or (2) a caregiver's willful deprivation of services necessary to maintain a patient's physical and mental

health.

The report must be made to the DMHAS commissioner, or her designee, within 72 hours after the suspicion or belief arose. Under the bill, a mandatory reporter is a behavioral health facility (1) employee paid to provide direct patient care or (2) employee, contractor, or consultant who is a licensed health care provider.

The bill requires behavioral health facilities providing direct patient care to (1) provide mandatory training to mandated reporters on detecting potential patient abuse and (2) inform them of their obligations to report abuse.

Additionally, the bill requires any other person having reasonable cause to suspect such patient abuse to report it to DMHAS in the same manner as the mandated reporters. The DMHAS commissioner, or her designee, must then inform the patient or the patient's legal representative of the services provided by Disability Rights Connecticut, Inc., the state's protection and advocacy system.

EFFECTIVE DATE: October 1, 2018

Report Contents

The bill requires a patient abuse report to include (1) the facility's name and address, (2) the patient's name, (3) information on the nature and extent of the abuse, and (4) any other information the mandatory reporter believes may help the investigation of the case or the patient's protection.

Report Confidentiality

Under the bill, a patient abuse report filed with DMHAS is not disclosable under the Freedom of Information Act. The DMHAS commissioner may disclose information derived from the report for which reasonable grounds are determined to exist after investigation, including the (1) facility's identity, (2) number of complaints received, and (3) number and types of substantiated complaints. But the bill prohibits her from disclosing the patient's name, unless the patient

requests it or a judicial proceeding results from the report.

The bill requires the commissioner, or her designee, to notify the patient's legal representative, if any, within 24 hours, or as soon as possible, after receiving a report of suspected abuse. The commissioner must obtain the legal representative's contact information from the facility.

Under the bill, notification is not required if the legal representative is suspected of causing the abuse that is the subject of the report.

Immunity from Liability

Under the bill, a person who reports suspected patient abuse to DMHAS or who testifies in any related administrative or judicial proceeding is generally immune from civil or criminal liability. The bill exempts from this protection perjury related to making the report, giving false testimony, or making fraudulent or malicious reports (see below).

Penalties

A mandated reporter who fails to report the abuse to DMHAS within the 72-hour deadline can be fined up to \$500. If the failure was intentional, the reporter can be charged with a class C misdemeanor (up to three months imprisonment, a fine of up to \$500, or both) for the first offense and a class A misdemeanor (up to one year imprisonment, a fine of up to \$2,000, or both) for any subsequent offense.

Additionally, a person is guilty of (1) making a fraudulent or malicious patient abuse report or (2) providing false testimony related to such a report, if he or she:

1. willfully makes a fraudulent or malicious report,
2. conspires with another person to make a fraudulent or malicious report or cause such a report to be made, or
3. willfully provides false testimony in any administrative or judicial proceeding related to the patient abuse report.

Violators are guilty of a class A misdemeanor and subject to up to one year imprisonment, a fine of up to \$2,000, or both.

Whistleblower Protection

Under the bill, a person who is discharged, or who is discriminated or retaliated against for making a patient abuse report in good faith is entitled to all remedies available by law.

§ 54 — PATIENT ABUSE INVESTIGATIONS

Requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients and establishes related requirements, such as disclosure of and access to patient abuse reports and investigations

The bill requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients she receives to determine the patient's condition and if any actions or services are required. The investigation must include:

1. an in-person visit with the patient;
2. consultation with individuals having knowledge of the facts surrounding the report; and
3. a patient interview, unless the patient refuses to participate.

After completing the investigation, the bill requires the commissioner to prepare written findings and recommended actions.

EFFECTIVE DATE: October 1, 2018

Investigation Results

The bill requires the commissioner, within 45 days after completing an investigation, to disclose its results in general terms to the person who reported the suspected abuse if the:

1. person who made the report is a mandated reporter (see § 53);
2. information is not otherwise privileged or confidential under state or federal law;

3. names of the witnesses or other people interviewed are kept confidential; and
4. names of the people suspected to be responsible for the abuse are not disclosed, unless they were arrested as a result of the investigation.

Disclosure of Records

Under the bill, DMHAS must maintain a statewide registry of the number of patient abuse reports it receives, the allegations in the reports, and the outcomes of the resulting investigations.

The patient's file, including the original abuse report and investigation report, is not disclosable under the Freedom of Information Act. The bill permits the DMHAS commissioner to disclose part or all of it to a person, agency, corporation, or organization if the patient or patient's legal representative consents to its disclosure or the disclosure is authorized under the bill. But it prohibits the commissioner from disclosing the name of the person who reported the suspected abuse, unless he or she provides written permission or a court order requires the name to be disclosed to a law enforcement officer.

Access to Records

The bill generally permits the patient, or the patient's legal representative or attorney, to access DMHAS records that pertain to or contain information or material concerning the patient. Such records include those concerning investigations; reports; or the patient's medical, psychological, or psychiatric examinations, except:

1. if it includes protected health information from someone other than a health care provider under the promise of confidentiality and the requested access would, with reasonable likelihood, reveal the information's source;
2. information identifying the person who reported the abuse, neglect, or exploitation cannot be released unless the patient

applies to the Superior Court, serves the DMHAS commissioner, and a judge determines, after a private records review and a hearing, there is reasonable cause to believe the person knowingly made a false report or that other interests of justice require the release;

3. if a licensed health care provider determines that the access is reasonably likely to endanger the life or physical safety of the patient or another person;
4. if the protected health information references another person, other than a health care provider, and the requested access would reveal the other person's protected health information; or
5. the access is requested by the patient's legal representative and a licensed health care provider determines in his or her professional judgment, that the requested access is reasonably likely to harm the patient or another person.

§§ 55-136 — OFFICE OF HEALTH STRATEGY

Effectuates the establishment of the Office of Health Strategy (OHS) pursuant to PA 17-2, JSS by making various minor, technical, and conforming changes; transfers administration of the Office of Health Care Access from DPH to OHS and renames the office the Health Systems Planning Unit

PA 17-2, JSS established the Office of Health Strategy (OHS), headed by an executive director appointed by the governor with confirmation by the House or Senate. It placed the office in DPH for administrative purposes only and made it the successor to the:

1. Connecticut Health Insurance Exchange for administering the all-payer claims database and
2. lieutenant governor's office for (a) consulting with DPH to develop a statewide chronic disease plan; (b) housing, chairing, and staffing the Health Care Cabinet; and (c) appointing the state's health information technology officer and overseeing the officer's duties.

The bill also transfers, from DPH to OHS, administration of the Office of Health Care Access and renames the office the Health Systems Planning Unit. Among other things, the office administers the state's certificate of need (CON) program for health care institutions. Under the CON law, health care facilities must generally receive state approval when (1) establishing new facilities or services, (2) changing ownership, (3) acquiring certain equipment, or (4) terminating certain services.

Additionally, the bill transfers, from the State Innovation Model Initiative Program Management Office to the OHS executive director, responsibility for studying the feasibility of creating a certification program for community health workers. As under current law, she must report the study results and recommendations to the Public Health and Human Services committees by October 1, 2018.

Finally, the bill effectuates OHS's establishment by making technical and conforming changes to various statutes.

Responsibilities

The bill adds to OHS's responsibilities, promoting effective health planning and providing health care in Connecticut in a manner that (1) ensures all residents' access to cost-effective health care services, (2) avoids duplicating these services, and (3) improves the availability and financial stability of these services.

Existing law requires the office to perform various responsibilities, such as coordinating the state's health information technology initiatives, developing and implementing a coordinated and cohesive health care vision for the state, and overseeing and directing the Office of Health Care Access, which the bill renames (see above).

Statewide Health Information Technology Plan (§§ 61 & 62)

The bill requires the OHS executive director, instead of the Health Information Technology Officer, to annually report to the Human Services and Public Health committees on (1) the statewide health information technology plan and related uniform data standards used

by specified human services agencies; (2) the statewide health insurance exchange; and (3) legislative, policy, and regulatory recommendations to promote the state's health information technology and exchange goals.

The bill also eliminates a similar requirement that the DSS commissioner annually report the statewide health information technology plan to the Appropriations, Human Services, and Public Health committees.

***State Health Information Technology Advisory Council
Membership (§ 65)***

The bill modifies the membership of the State Health Information Technology Advisory Council by:

1. removing the director of the State Innovation Model Initiative Program Management Office, or the director's designee;
2. adding one member appointed by the OHS executive director, who must be an expert in state health care reform initiatives; and
3. replacing one Connecticut State Medical Society member with a licensed physician appointed by the Senate president pro tempore.

By law, the council advises the state's health information technology officer and, under the bill the OHS executive director, on the statewide health information technology plan and standards for the state's health information exchange, among other things.

Office of Health Care Access (§§ 68-114 & 120-133)

The bill transfers, from DPH to OHS, administration of the Office of Health Care Access (OHCA) and renames the office the Health Systems Planning Unit (HSPU). Among other things, the HSPU administers the state's certificate of need (CON) program for health care institutions. Under the bill, any OHCA order, decision, agreed settlement, or regulation in force on July 1, 2018 is effective until it is amended, repealed, or superseded by law.

Additionally, the bill grants the DPH deputy commissioner independent decision making authority over pending CON applications completed before July 1, 2018. Any further action required after the DPH deputy commissioner issues final decisions on these applications will be decided by the OHS executive director.

The bill imposes a new deadline, October 1, 2018 instead of October 1, 2011, for HSPU to enter into a memorandum of understanding with the comptroller to allow him access to specified collected data from hospitals and outpatient surgical facilities. Such data includes, among other things, patient-identifiable inpatient discharge data, emergency department data, and outpatient provider and patient data. Existing law, unchanged by the bill, requires the comptroller to agree in writing to keep confidential individual patient and provider data, identified by name or personal identification code (§ 94).

Community Health Workers (§ 117)

The bill transfers, from the State Innovation Model Initiative Program Management Office to the OHS executive director, responsibility for studying the feasibility of creating a certification program for community health workers. As under current law, the OHS executive director must do this within available appropriations, and in consultation with the Community Health Worker Advisory Committee.

The OHS executive director must report the study findings and recommendations to the Public Health and Human Services committees by October 1, 2018.

Insurance Assessment to Fund OHS (§§ 118 & 119)

The bill requires Connecticut insurance companies and hospital and medical service corporations to annually pay the insurance commissioner an amount that covers OHS's appropriation, including fringe benefits and capital equipment purchases, except for those made on behalf of HSPU.

Existing law already requires insurance companies and hospital and

medical service corporations to annually pay the insurance commissioner the (1) actual expenditures, including fringe benefits and capital equipment purchases, of the Insurance Department and Office of the Healthcare Advocate and (2) an amount that covers the Department of Social Services' fall prevention program appropriation. As under current law, the bill requires the insurance commissioner to deposit these payments in the Insurance Fund.

The bill makes related technical and conforming changes to the statutory requirements for determining and notifying insurers of their annual assessment amounts.

§§ 135 & 136 — REPEALERS

Repeals obsolete provisions in various DPH- and DMHAS-related statutes

The bill repeals obsolete provisions:

1. requiring DMHAS to complete a program at CVH to consolidate inpatient mental and substance abuse services (CGS § 17a-451b);
2. substituting "Whiting Forensic Institute" for "Whiting Forensic Division" in various statutes (CGS § 17a-560a);
3. establishing an effective date for statutes on evaluating and treating certain individuals with psychiatric disabilities who commit crimes (CGS § 17a-576);
4. establishing a behavior analyst licensing fee expense account within the General Fund to contain behavior analyst license fees to cover necessary DPH staff and equipment costs to collect the fees (DPH now funds the licensure program through its General Fund appropriation and no longer needs a dedicated account) (CGS § 20-185n);
5. transferring, from John Dempsey Hospital to the Connecticut Children's Medical Center, licensure and control of certain neonatal intensive care unit beds after receiving a certificate of need from DPH (CGS § 10a-109ii);

6. (a) requiring DSS to notify the Newington Children's Hospital of each referral for whom it can apply for federal matching grants and (b) permitting the state to pay the hospital retroactive claims related to federal reimbursement claims (CGS §§ 17b-234 & 17b-235);
7. authorizing a demonstration project for long-term acute care hospitals or satellite facilities (CGS § 19a-617b);
8. requiring OHCA to promote effective health planning in the state (CGS § 19a-637);
9. requiring the Lieutenant Governor to designate an individual to serve as Health Information Technology Officer (the bill transfers this responsibility to OHS)(CGS § 19a-755); and
10. requiring OHCA to adopt certain regulations by April 1, 1977 (CGS § 38a-558).

EFFECTIVE DATE: July 1, 2018, except that the first four repealed provisions listed above take effect upon passage.

BACKGROUND

Related Bills

sSB 404, favorably reported by the Public Health Committee, also requires mandatory reporting of suspected patient abuse at DMHAS-operated facilities by specified employees and health care providers.

sSB 406, favorably reported by the Public Health Committee, also subjects Whiting Forensic Hospital to DPH licensure and regulation and makes similar statutory changes to effectuate the hospital's separation from CVH.

sHB 5290, favorably reported by the Public Health Committee, makes similar minor, technical, and conforming changes to effectuate the establishment of OHS.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 24 Nay 3 (03/23/2018)